STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES

November 4, 2008 9:00 a.m. – 4:00 p.m.
Country Inn and Suites, 5353 No 27th Street, Lincoln, NE

AGENDA

9:00 a.m.

I. Welcome and Introductions	Bev Ferguson	Call to order
II. Attendance – Determination of Quorum	Alexandra Castillo	Roll call
III. Approval of August 12, 2008 Minutes	Bev Ferguson	General consent
IV. Approval of Agenda	Bev Ferguson	General consent
V. Housekeeping	Jim Harvey	Inform

• BRFSS and PHQ-8 Report	Paula Hartig
• State Public Counsel (Ombudsman's Office) and LB467	Marshall Lux and Carl Eskridge
• Report on the Behavioral Health Oversight Commission	Scot Adams
• Response to Committee Recommendations of August 12, 2008	Scot Adams
• LR 363 Hearing	Scot Adams
• Proposal on Transformation Transfer Initiative	Scot Adams
• Magellan Quality Improvement Team	Sheri Dawson
• Regional Center Wait list and the Emergency System	Mary O'Hare
• Office of Consumer Affairs Report	Dan Powers
• Mental Health Block Grant Implementation Report and URS Tables	Jim Harvey
• Criminal Justice Grant Report	Jim Harvey

WORKING LUNCH

• Region 1 BH Report (by phone starting at 12:30)	Sharyn Wohler
• MH Block - Committee Recommendations for Letter by Chair	Committee Discussion
• Mental Health Awareness Week	Vicki Maca
• Arbor Program	Maya Chilese
• Update on Secure Care Facility / CD Treatment	Beth Baxter/ Maya Chilese
• RentWise	Pat Talbot
• Other – agenda items added at meeting only if an emergency exists	

PUBLIC COMMENT

- Each person wishing to speak at the meeting needs to sign up on the Public Comment Sign-in List.
- Each person will be called on from the Public Comment Sign-in List in order of sign-in. Each person may have 5 minutes (unless the chair grants more time) to provide comments. Public comments not provided verbally may be mailed to the Division of Behavioral Health, Attention: Alexandra Castillo.

Mental Health Committee Questions / Recommendations to Division of Behavioral Health

AGENDA ITEMS FOR NEXT MEETING	ALL
PLUS/DELTA	ALL
4:00 p.m. ADJOURN	Bev Ferguson

Next scheduled meeting is February 5, 2009.

State Advisory Committee on Mental Health Services
November 4, 2008 – 9:00 A.M. to 4:00 P.M.
Country Inn & Suites – 5353 No. 27th St. Lincoln, NE
MINUTES

Committee Members Present:
Adria Bace, Beth Baxter, Leslie Byers, Pat Compton, Cheryl Crouse, Bev Ferguson, Scot Ford, Dwain Fowler, Clint Hawkins, Frank Lloyd, Vicki Maca, Colleen Manthei, Jerry McCallum, Pat Talbott, Diana Waggoner

Committee Members Absent:
Jimmy Burke, Chelsea Chesen, Roxie Cillessen, Joliene Hall, Chris Hanus, Morgan Hecht, Susan Krome, Kathy Lewis

DHHS Staff Present:
Jim Harvey, Scot Adams, Dan Powers, Maya Chilese, Paula Hartig, Alexandra Castillo, Sheri Dawson, Mary O'Hare

Others Present:
Carl Eskridge, Marshall Lux, Linda Jensen

I. CALL TO ORDER

Bev Ferguson, Chairperson called the meeting to order at 9:00 a.m.

Roll call of members determined a quorum was met. **15 Members** of 23 appointed members were present at the beginning of the meeting. Each member introduced themselves and gave a brief statement about themselves.

II. APPROVAL of August 12, 2008 MINUTES

√ Motion was made by Scot Ford and seconded by Colleen Manthei to approve the August 12, 2008 minutes as submitted. Voice vote was unanimous. Motion passed.

III. APPROVAL OF AGENDA

√ Motion was made by Jerry McCallum and seconded by Scot Ford to accept the November 4, 2008 agenda as submitted. Voice vote was unanimous and motion carried.

Bev Ferguson was asked by Jeff Santema to present an informational report to new Senators on Thursday, November 6, 2008, regarding the State Advisory Committee on Mental Health Services such as to what the Committee does, history, goals, etc. She has started a report with some history and asked for comments from the committee. Bev will send a copy of the report to all Committee members.

IV. DHHS BEVAVIORAL HEALTH REPORTS

BRFSS and PHQ-8 Report
The Mental Health Data Grant includes funds for further analysis. Paula Hartig, DHHS Program Analysis and Research Administrator stated the Summary is a survey done in 50 states, asking the same exact questions. The survey looks at health risk behaviors/unhealthy behaviors to identify health risk factors for those disorders. Detailed information is contained in **Attachment #1**

State Public Counsel – LB467
Presenters; Marshall Lux and Carl Eskridge are from the Ombudsman's Office. The Ombudsman's office was established in 1971. The purpose of the Ombudsman's Office is to take care of citizen's complaints related to the Administration Agencies of State Government, such as Dept. of Correction, Dept. Of Motor Vehicles, Veteran's Homes and Health and Human services. The 2 goals of the

Ombudsman's Office are: 1) Administrative Justice for complaints and 2) to improve Government Agencies based on what was investigated related to the complaints.

LB467 relates to the role of the Ombudsman. New legislation created a new position, Deputy Ombudsman for Institutions. The Deputy Ombudsman for Corrections was created in 1974 and receives an abundance of complaints. The point of the legislation is to have the Ombudsman's office concentrate more on the Institutions run by Health and Human System. The real problem is getting complaints from the Veteran's Home, Beatrice State Developmental Center and the Regional Centers. The Deputy Ombudsman for Institutions' Jurisdiction was enlarged to include all mental health facilities, all Regional Health Authorities that provide services and all Community Based Behavioral Health Service providers that contract with any Regional Health Authorities and to any person released within 12 months from a state/government owned facility who provided services.

Question: To get help does a family member need to have been institutionalized?
Answer: The Ombudsman's office needs to hear the specifics of each incident to determine if it is within their jurisdiction. Please call the Ombudsman office at 402 471-2035 or 800 742-7690

Concerns: Consumers at the Regional Center don't have a way to use the telephone to make a private call. They fear for themselves from staff members.

Behavioral Health Oversight Commission
Scot Adams mentioned the BHOC is a Governor appointed Commission, to develop a strategic vision for Behavioral Health within existing resources. There are 4 workgroups working with 1) Overview of the Behavioral Health System and reports on regions, the state perspective and the consumer perspective 2) Work force issues looking at a variety different ways including a variety of professional, consumer and peer support 3) The topic of moving behavioral health forward on how to improve 4) Improving communication between and among the Division and Regions and between Consumers and Providers at all level of activities. Scot encourages this committee's suggestions and input to BHOC. The BHOC minutes are posted on the HHS Website www://dhhs.ne.gov/behavioral_health/

Responses to State Advisory Committee on Mental Health Services Questions and Comments from August 12, 2008
Scot Adams reviewed questions/comments received from the Advisory Committee. **Attachment # 2**

LR 363 Hearing
Scot Adams shared information presented at the LR363 hearing that relates to Behavioral Health.
Q. What is the status of the Housing Program?

A. The housing program is improving with growing numbers but is still young, this is the 4th year. There are some limits to get housing, which is low amount of facilities. It is a very flexible program to help individuals to be good renters. Housing Coordinators Information can be obtained on the website. http://www.dhhs.ne.gov/beh/Housing/HousingContacts.htm **Attachment #3**

Proposal on Transformation Transfer Initiative
Scot Adams stated the Transformation Transfer Initiative Application is an opportunity to gain funds ($221,000) to work on training consumers for participation in the system. The application was reviewed with the committee. The proposal shows what Nebraska plans to do, timelines and a project budget. The Division asked for Committee's recommendation regarding this application. A copy of the application is **Attachment #4.**

Motion made by Dwain Fowler and seconded by Diana Waggoner "This Committee recommends support for this proposal and it is timely in the State's transformation. This includes Peer Support for both the Consumer and the Family". Voice vote was unanimous. Motion passed.

Magellan Quality Improvement Team
Sheri Dawson informed the Committee the Division's plans regarding Magellan Quality Improvement. Goals of the Team and a list of Team participants are included in **Attachment #5.**

Regional Center Wait List & the Emergency System
Mary O'Hare informed the committee of the capacity numbers at the Regional Centers, Regional Center status and services. The number of beds at the Regional Centers are down and it's getting better. Three years ago the Norfolk Regional Center had 179 people and now only has 11. The power point presentation is **Attachment #6**

Suggestion was made that in working the nursing home issues that there be communication with Housing coordinators.

Region 1 BH Report
Sharyn Wohler - briefly reviewed the functions and the services offered in Region 1. Region 1 is made up of 11 Panhandle counties. A list of providers and the services they provide are included in the power point. Region 1has developed a system of care team, a youth system team and has built a good relationship to help each other. They have a group of providers working to develop methods to help youths with transition. The Region 1 Family Organization is Speak Out. **Attachment #7**

This is the last Regional report for this calendar year and the committee agreed to continue with the Regional reports in 2009 to get information on Behavioral Health Reform and some focused topics; such as Transition of the systems, Peer Support projects, transitioning of youth, evidence based employment programs, updates on children's mental health and partnering with the schools. Beth Baxter will work with the Regions to set up the regional report for next meeting.

Office of Consumer Affairs Report
Dan Powers reported the Annual Consumer Conference was held Sept 16-18, 2008 in Aurora Nebraska titled; "One Voice Moving Toward Recovery". A total of 73 consumers attended and 60 of those were first time attendees. Key speakers were: Kim Carpenter, Director of Nebraska Coalition for Women Treatment, Ken Timmerman, Region 6 Consumer Specialist, Steve Harrington, Director of National Association of Peer Specialist, and Dr. Stewart Monroe from the Kansas City University Department of Psychiatry. The total cost of the conference was $16,084. The overall Conference satisfaction was very good.

Phyllis McCaul is assigned to work at the LRC. She is doing support groups, WRAP training, Rent Wise training, and helping other groups as needed.

The Regional Peer Specialist are looking into Peer Support Training, they have a 3 tier curriculum. Tammy Fiala, Lisa Sullivan and Ken Timmerman plan to attend the Connecticut Peer Support training in February 2009. Judy Moorehouse has already attended that training.

MH Committee's letter to the Governor
Bev Ferguson wrote a letter on behalf of the committee to the Governor November 6, 2007 regarding six Behavioral Health Service staff vacant positions. Bev received a response letter from Scot Adams and an organizational chart showing restructure of positions and duties. This restructure of positions and duties will strategically help with the Division workflow. **Attachment #8**

MH Block Grant Implementation Report
Jim Harvey and Bev Ferguson attended the MH Block Grant review in Glendale Arizona on October 21, 2008. The result is that the Nebraska Mental Health Block Grant was accepted as submitted. **Attachment # 9**

Jim Harvey reviewed the draft of the Mental Health Block Grant Implementation Report. A new section starts in page 20 on how funds were used and the recipients of Grant funds. **Attachment # 10**

The URS Table
Jim Harvey briefly reviewed the URS tables but informed the committee that there is some serious data reporting problems and some tables are under reported. The Division will continue to work with UNMC to correct the data. The revised tables are still to come and will be shown to the committee at the next meeting. **Attachment #11**

Comment: The tables show outcomes for children are low and were also low last year. It's important to have family involved to increase and support the outcomes. Family involvement is required in the Professional Partner programs and the Children's MH services.

Beth Baxter made a recommendation for the Division to do a comparison of the Consumer Survey Youth Data to the Professional Partner's Satisfaction Survey.

Mental Health Block – Committee Recommendations for Letter by Chair
As the Committee's Chairperson, Bev Ferguson will be writing the required Committee letter on the Implementation Report.

Comments collected from the committee as to what should be included in the letter are:
- URS tables are in need of improvement
- Give credit to the Division in trying to get better URS tables
- Children low outcomes and Division will check into possible reasons for low reporting.

Copy of letter will be available at the next meeting for the Committee to view.

MH Awareness Week
Mental Health Awareness was observed during the month of October. NAMI had a very nice display located on the first floor of the Nebraska State Office building.

SIG Team is looking at the organizations of family services and how services can be done better.

Informing the Senators may be an opportunity to get funds targeted toward adolescence services and to prevent child abandonment.

Arbor Program
Maya Chilese explained the Arbor Program is funded by DHHS Children and Family Services Economical Support Division. Arbor Program is a contractor that falls under employment first/ Welfare to Work program. Young mothers who are unemployed and receive food stamps and/or ADC dollars are required to participate. The intent is a good product.

Question: If a parent and or child have a pre existing Mental Health or Behavior struggle, that impedes them in the Arbor Program process is there an assessment/screening to help the individual? Are the workers aware were to refer the parents and are the worker educated on how to help? Division staff will check into it and report back to the committee.

Update on Secure Care Facility/CD Treatment
Maya Chilese informed the committee that state government is trying to figure out details to build the building. They are looking at a new location and possibilities for the new building that will be more efficient. Currently they are not at the stage of addressing what are the facility's services.

Criminal Justice Meeting Report
Jim Harvey stated the Category I is now complete and are going onto the Category II, Planning and Implementation with the 5 Goals. **Attachment #12**

RentWise
Pat Talbott shared her concern with the committee on an issue of nonpayment of an instructor for doing a RentWise training.

Committee recommends the Division do a complete investigation on the process that occurred regarding the RentWise training and why David Tafoya has not received payment.

Jim could not address the concern because he was not informed on the complete issue but the Division will check into it and do what can be done to resolve the issue. **Attachment #13**

V. Mental Health Advisory Committee Recommendations to BH Division

- Request the Division to check on the Arbor Program process is there an assessment/screening to help the individual.
- Recommend the Division to do a comparison of the Consumer Survey Youth Data to the Professional Partner's Satisfaction Survey.
- Recommends the Division to investigate the process that occurred regarding the RentWise Training.

VI. Meeting Agenda Items

- Division's Response to recommendations
- Region 3 Report
- Consumer Survey
- URS Tables

VII. Plus/Delta

Committee is getting better – being open with each other
Good productive meeting
Chairperson has good control of meeting

VIII. Adjournment & Next Meeting

√ Motion made by Jerry McCallum and seconded by Clint Hawkins to adjourn the meeting. Voice vote was unanimous. Motion passed.

The next meeting date is **Thursday, February 5, 2009** at Country Inn and Suites.
Meeting adjourned at 4:00 pm.

Prepared by: Alexandra Castillo, Staff Assistant

Approved by _____ Date 1/23/09
Division of Behavioral Health

Prevalence of Anxiety, Depression and Alcohol Abuse Among Adults in Nebraska
Summary[1]

Prepared for review by the State Advisory Committee on Mental Health Services
November 4, 2008

Background

To assess the health status of persons with mental illness in Nebraska, the Division of Behavioral Health contracted with the Division of Public Health to add questions to the annual Nebraska **Behavioral Risk Factor Surveillance System (BRFSS)** that could be used to: a) produce estimates of the presence of certain mental disorders, and substance use disorders, in the adult population in Nebraska; and b) identify health risk factors associated with those disorders. The instrument used was the Anxiety/Depression Module which was administered to 3,990 BRFSS[2] respondents across Nebraska.

The Anxiety/Depression Module consisted of two sets of questions intended for use in estimating the following:

- the prevalence of **current depression** in the adult population
- the prevalence of **lifetime depression** in the adult population
- the prevalence of **lifetime anxiety** in the adult population

In addition, one question from the core BRFSS "Healthy Days – Health-Related Quality of Life" section was used to determine the prevalence of **frequent mental distress** (FMD) in the adult population.

To estimate the prevalence of **current depression**, a Severity of Depression Scale was constructed using a standardized scale known as the Patient Health Questionnaire, or PHQ-8. The PHQ-8 was developed at Columbia University and is an easily administered tool for primary care physicians to use in diagnosing depression. Each question in the Questionnaire asks the respondent to state the number of days within the past two weeks that they have been affected by a particular mood. Specifically: "Over the last two weeks, how many days have you:

- had little interest or pleasure in doing things?
- felt down, depressed or hopeless?
- had trouble falling asleep or staying asleep or sleeping too much?
- felt tired or had little energy?
- had a poor appetite or eaten too much?
- felt bad about yourself or that you were a failure or had let yourself or your family down?
- had trouble concentrating on things, such as reading the newspaper or watching the TV?
- moved or spoken so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?

---

[1] For a copy of the full report: "*A Report of Prevalence of Anxiety and Depression Among Adults in Nebraska in 2006*" contact the author, Meridel Funk at (402) 471-0198 or at meridel.funk@nebraska.gov. The report is also available on the Division of Behavioral Health's website.

[2] The BRFSS surveys are based on a research design developed by the Centers for Disease Control and Prevention (CDC). The BRFSS is used in all 50 states, the District of Columbia, and three U.S. territories. Questions are standardized to ensure comparability of data with other states and to allow determination of trends over time.

An algorithm developed at the CDC was then used to reconfigure the scores into the Severity of Depression Scale. Scores on the PHQ-8 of 10 or greater indicate that the respondent has **current depression**, while scores of less than 10 denote "mild or no current depression". Based upon the responses to the PHQ-8, it is estimated that six percent (6%) of adults responding to the 2006 BRFSS have **current depression**. Applying this rate to the 2006 population of adults aged 18 and older in Nebraska, an estimated 79,398 adults had depression in the two weeks prior to the survey.

The Anxiety/Depression Module also included a second set of questions intended to estimate the lifetime prevalence of anxiety and/or depression. Those questions were:

- Has a doctor or other healthcare provider EVER told you that you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?
- Has a doctor or other healthcare provider EVER told you that you had an anxiety disorder (including acute stress disorder, panic disorder, phobia, posttraumatic stress disorder, or social anxiety disorder)?

Altogether, 18 percent (rounded) of respondents to the 2006 Nebraska BRFSS reported a **lifetime diagnosis of depression, anxiety, or both**. Based upon this prevalence rate, it is estimated that in 2006, 238,194 adults in Nebraska had ever been diagnosed with anxiety and/or depression. Nine percent of respondents reported having been diagnosed with a **depressive disorder only**, three percent reported having been diagnosed with an **anxiety disorder only**, and seven percent reported having been diagnosed with **both anxiety and depression**. Combining respondents who only reported a lifetime diagnosis of depression and those who reported having been diagnosed with both anxiety and depression, 16 percent had a lifetime diagnosis of a depressive disorder. Similarly, 10 percent overall had a lifetime diagnosis of an anxiety disorder.

Eight percent of respondents to the BRFSS reported 14 or more days in the past 30 days when their mental health was "not good". These respondents were categorized as having "frequent mental distress".[3]

There were also two questions on the BRFSS intended for use in estimating the prevalence of "**binge drinking**" (which for men means five or more drinks of alcohol on an occasion, and for women four or more drinks of alcohol on an occasion, one or more times during the previous 30 days), and "**heavy (chronic) drinking**" (which is based upon the average number of drinks of alcohol consumed per day during the previous 30 days). Based upon survey responses, an estimated 15 percent of adults in Nebraska engaged in binge drinking but not heavy drinking; less than one percent participated in heavy drinking but not binge drinking; and three percent qualified as binge drinkers and heavy drinkers. Thus, 18 percent of adults reported alcohol abuse in the month prior to the survey, translating to an estimated prevalence of alcohol abuse among Nebraska adults of 238,194.

[3] The specific question on the BRFSS survey was: "Now, thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good?"

Co-Occurrence of Mental Disorder and Alcohol Abuse

Only one percent of ALL respondents reported current depression and alcohol abuse. However, the six percent of adults who were classified as having current depression also reported alcohol abuse. Among persons with a lifetime diagnosis of depression, 13 percent reported alcohol abuse in the past month. For respondents with a lifetime diagnosis of anxiety, 17 percent also indicated abuse of alcohol within the last 30 days.

Association of Mental Disorders with Chronic Disease

One of the benefits of including mental health questions on the BRFSS is the ability to examine the prevalence of chronic disease (i.e., coronary heart disease, stroke, asthma and diabetes) among persons with mental disorders. A report released in 2006 by the National Association of State Mental Health Program Directors, titled "Morbidity and Mortality in People with Serious Mental Illness", reported that persons with serious mental illness (SMI) die, on average, 25 years earlier than the general population. The report concluded that their [SMI] increased morbidity and mortality are largely due to treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity and substance abuse.

The survey found that the prevalence rates for some chronic diseases were significantly higher among adults with the mental disorders addressed in this study than among those respondents who did not have a mental disorder. For example, rates of coronary heart disease were significantly higher among persons with current depression, FMD, or lifetime diagnoses of both anxiety and depression than among those without these mental disorders.

The prevalence of **coronary heart disease** was significantly higher for persons who had ever been diagnosed with both depression and anxiety at some time in their lives than it was for persons who were never diagnosed with either of those conditions (Figure 1). The prevalence of **stroke** was significantly higher among persons with current depression, FMD, or a lifetime diagnosis of anxiety only (Figure 2). **Diabetes** was also significantly more prevalent among persons with current depression/FMD and among persons ever diagnosed with anxiety and depression (Figure 3). Compared to respondents without these mental disorders, significantly higher rates of **asthma** were found among respondents with a lifetime diagnosis of depression, with current depression/FMD, or with a lifetime diagnosis of both depression and anxiety (Figure 4).

Association of Mental Disorders with Unhealthy Behaviors

Cigarette smoking (Figure 5) and **physical inactivity** (Figure 6) were both significantly more prevalent among persons with all of the mental disorders included in this survey. **Obesity** was also significantly more prevalent among persons with current depression, current depression/FMD, or lifetime diagnoses of both depression and anxiety (Figure 7). However, no significant association was found between prevalence of current depression or lifetime diagnoses of anxiety and/or depression and alcohol abuse (Figures 8 and 9). That is, rates of alcohol abuse for persons with these mental disorders were not significantly higher than corresponding rates for persons without these mental disorders.

Association of Alcohol Abuse with Chronic Diseases and Unhealthy Behaviors

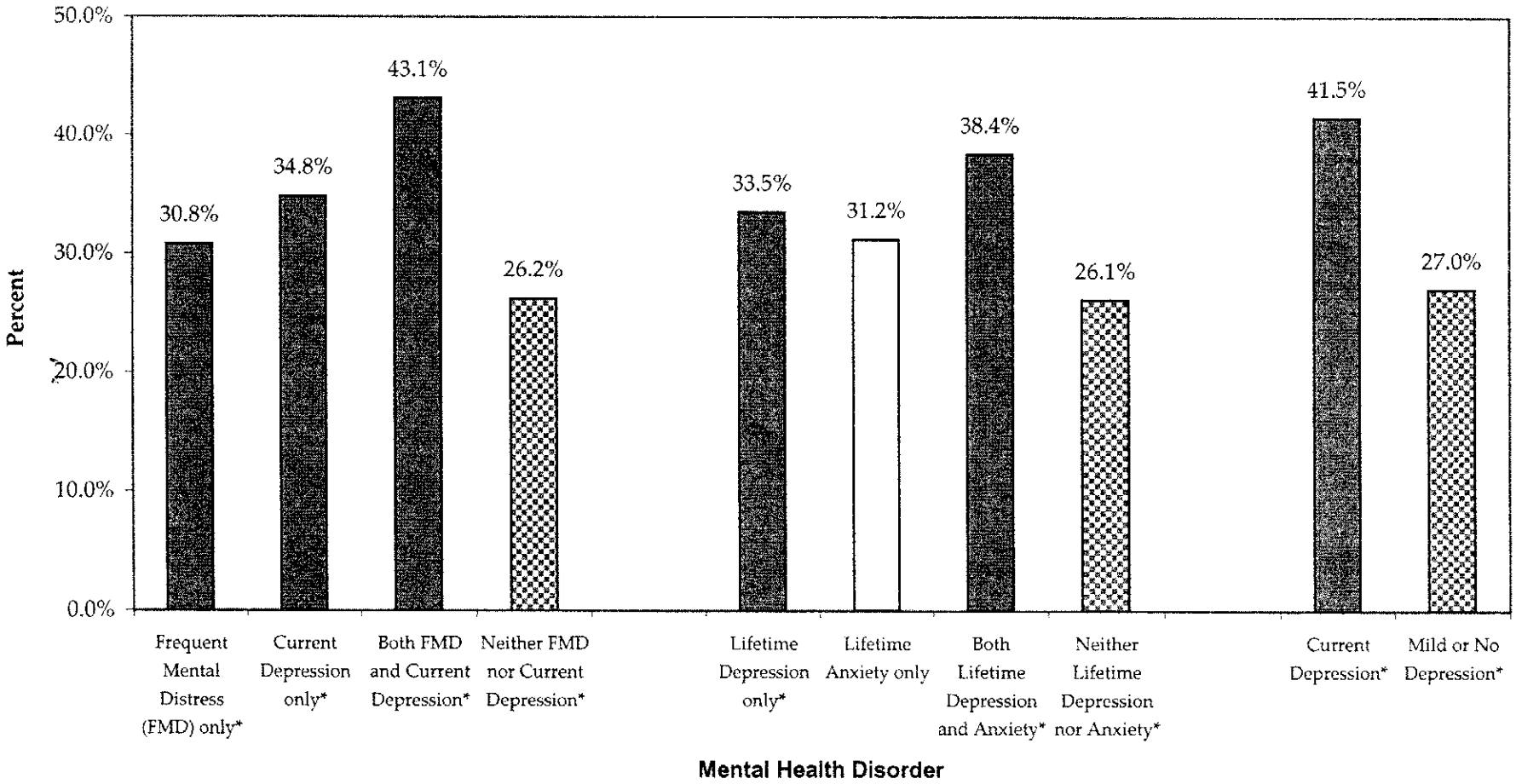
Of the four chronic diseases studied by alcohol abuse, a significant difference in prevalence was noted only for diabetes -- prevalence of diabetes was significantly lower among persons who reported current binge drinking than among those who reported no alcohol abuse. (This result may be due in part to the fact that diabetes is more prevalent in middle-aged or older adults, while binge drinking rates are highest among young adults.)

The prevalence of cigarette smoking was significantly higher among respondents who engaged in binge drinking, or in both binge and heavy drinking, than it was among those who reported no alcohol abuse in the past 30 days.

Conclusion

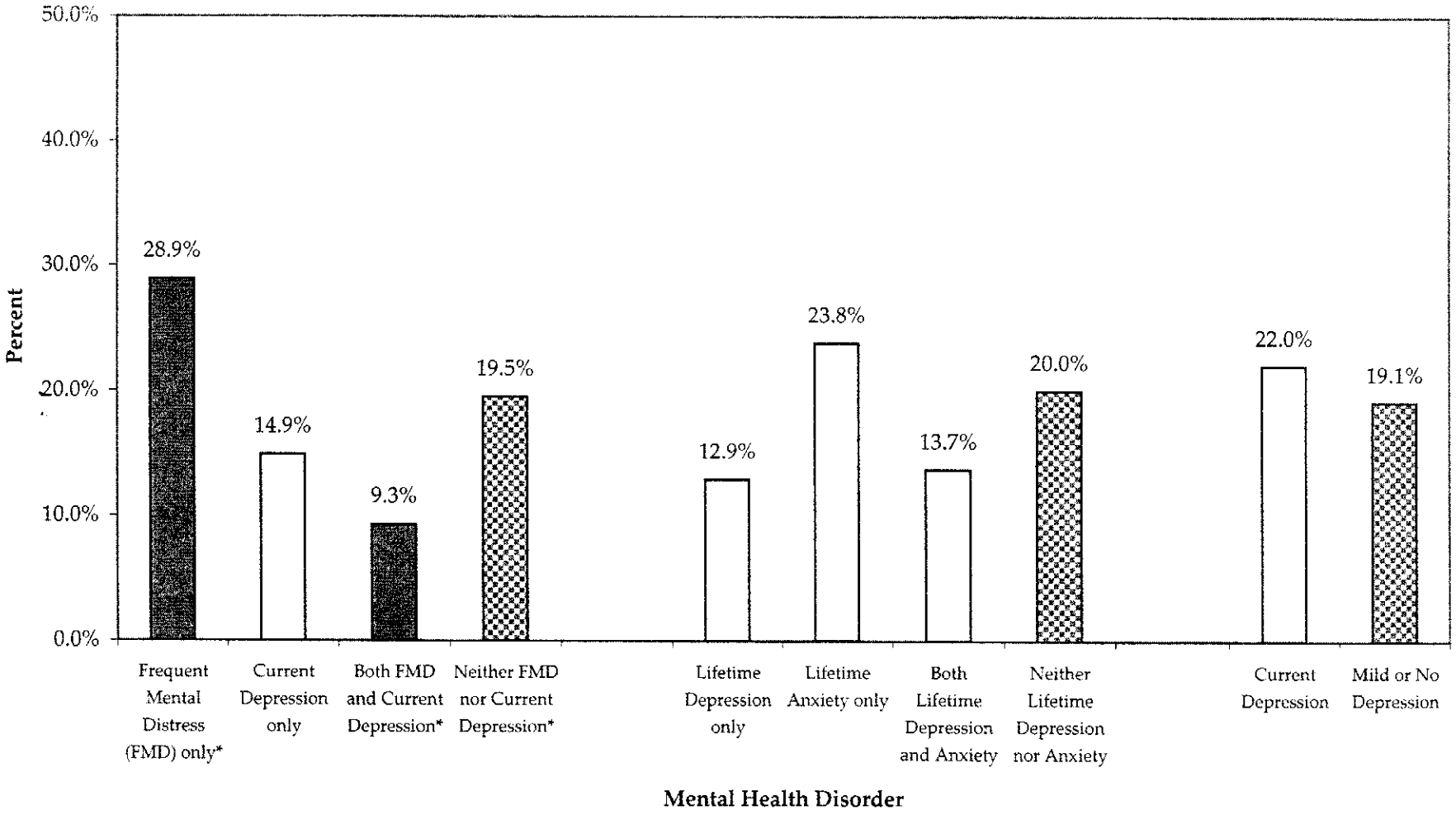
The BRFSS survey, the NASMHPD report and other studies, suggest that there is a significant link between a person's mental health and his or her physical health, a finding that has important implications for practitioners in both the behavioral health system and the physical health/public health system. The good news is that many of the high-risk behaviors that contribute to coronary heart disease, stroke, asthma and diabetes are modifiable. Even a small increase in leisure-time physical activity, or a decrease in smoking, could have a noticeable impact on the life expectancy of persons with serious mental illness.

Figure 7 - Prevalence of Obesity by Mental Health Disorder



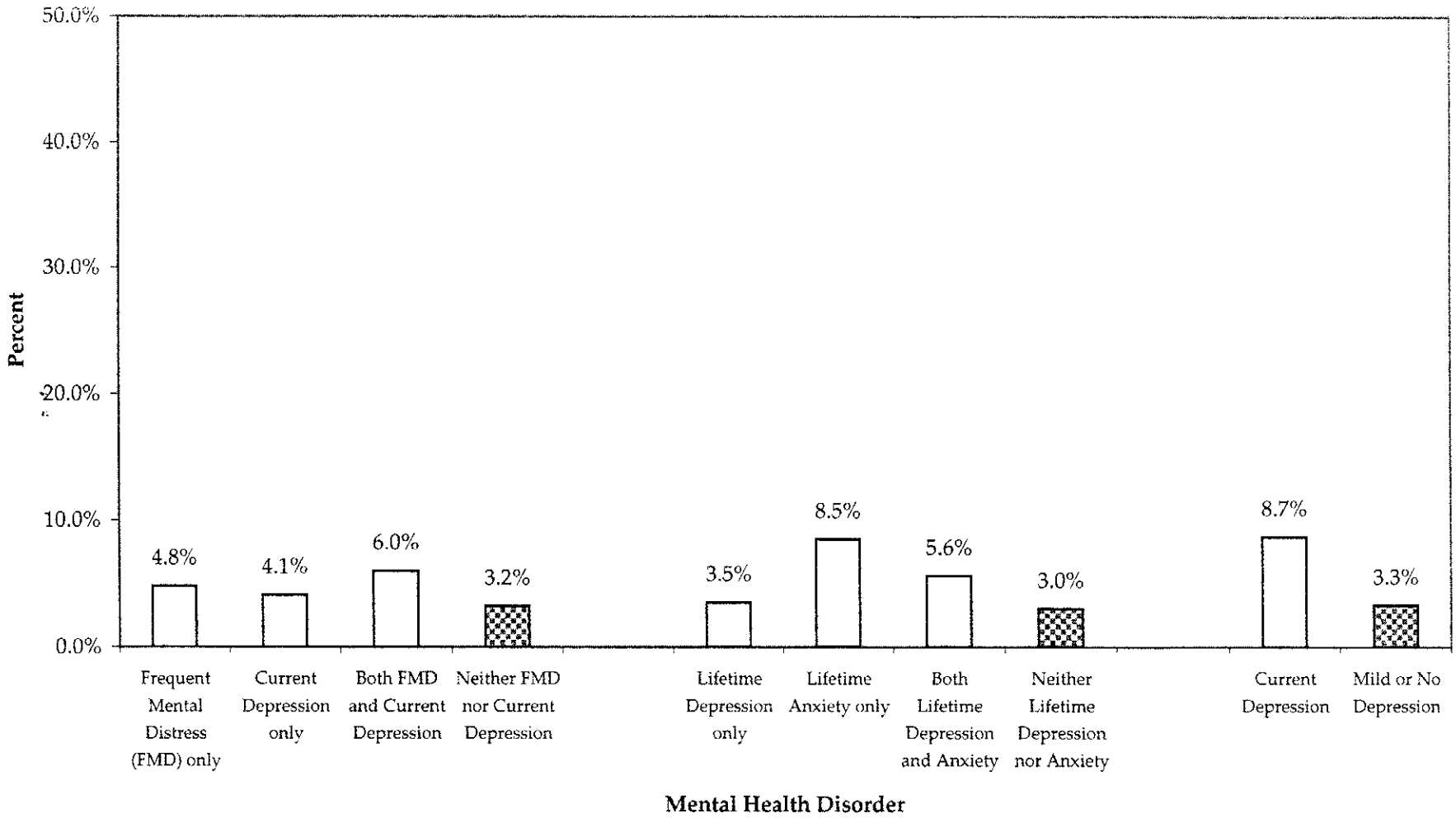
* Statistically significant differences in prevalence of unhealthy behavior

Figure 8 - Prevalence of Binge Drinking by Mental Health Disorder



* Statistically significant differences in prevalence of Binge Drinking

Figure 9 - Prevalence of Heavy Drinking by Mental Health Disorder



* Statistically significant differences in prevalence of Heavy Drinking

October 27, 2008

To: Beverly Ferguson, Chair
State Advisory Committee on Mental Health Services

From: Scot L. Adams, Ph.D., Director, Division of Behavioral Health

Re: Division of Behavioral Health Responses to State Advisory Committee on Mental Health Services Questions and Comments from August 12, 2008

Based on the minutes of the meeting from August 12, 2008, the following Committee questions and comments were identified. The Division of Behavioral Health responses will be reviewed at the State Advisory Committee on Mental Health Services on November 4, 2008.

State Advisory Committee on Mental Health Services Questions and Comments to the Division of Behavioral Health from the August 12, 2008 meeting were:

The Committee Asked

Recommend to the Division to have a breakdown of the population serviced to help determine the Professional services dealing with children and not just adults.

Division of Behavioral Health Response

This is an issue addressed under GAP #4: SHORTAGE OF BEHAVIORAL HEALTH WORKFORCE within the Federal Community Mental Health Services Block Grant. The Health Professionals Tracking Center (HPTC) at the University of Nebraska Medical Center prepares the information reported under GAP #4. Since 1995 HPTC has effectively developed and maintained a centralized, state of-the-art repository of information regarding Nebraska's health care resources. In general, HPTC reports there remains a critical shortage of qualified Nebraska behavioral health staff for providing treatment, rehabilitation and support services as well as handling administrative functions. The shortage of credential staff includes psychiatrists, psychologists, mental health practitioners, nurses, as well as alcohol and drug counselors.

On August 12, 2008, the NE FY2009 draft application for the Mental Health Block Grant was formally reviewed by State Advisory Committee on Mental Health Services. Members of the Committee asked to have the Health Professions Tracking Center to report on the populations served by behavioral health professionals such as only children, only adults or both to help document the lack of pediatric mental health professionals.

On August 25, 2008, the Health Professions Tracking Center responded with a preliminary analysis based on what could be completed within the time available. The

data used in the report below is restricted to the following five age categories: Child: 0 - 12 years; Adolescent: 12 - 18 years; Young Adult: 19 - 25 years; Adult: 26 - 64 years; and Geriatric: 65 +. The data are reported under "Behavioral Healthcare Professional – Patient Age Details by Region" (as of August 22, 2008) on pages 99 to 101 in the FY2009 Nebraska application for the Federal Community Mental Health Services Block Grant. This FY2009 application is posted on the Division of Behavioral Health web site under Mental Health Services, Grants and Reports: Mental Health Block Grant Fiscal Year 2009 Application
http://www.dhhs.ne.gov/beh/mh/mh.htm

For more information on Health Professional Shortage Areas contact Thomas Rauner in the Nebraska Department of Health and Human Services (DHHS), Office of Rural Health and Primary Care (402-471-0148).

The Committee Asked
Recommend the Division to do away with the over medication of children and use more therapy.

Division of Behavioral Health Response
This is a nationwide issue. The Division of Behavioral Health does provide funding for medication (FY2009 Regional contracts for Medication Management total is $1,008,400; the LB95" Psychiatric Medications Indigent Drug Reimbursement in FY2008 was $2,135,203.72). However, most of the DHHS funding for behavioral health drugs is from Medicaid.

Nebraska Medicaid Behavioral Health Drug Expenditures

	Age 0 through 17	Age 18 and older	Total
FY2008	$25,186,739.28	$37,353,287.64	$62,540,026.92

The medications are dispensed by both behavioral health providers and other authorized medical professionals in Nebraska.

We recognize the concerns in the field from families whose children's are recipients of over medication. Medicaid has a drug education program. Dr. Blaine Shaffer, Chief Clinical Officer for the Division of Behavioral Health, serves on this committee. More recently, several brochures were published in collaboration with State Infrastructure Grant (SIG) and the Nebraska Federation of Families for Children's Mental Health to address the use of psychotropic medicines, what to ask, what to know. SIG is a Federal grant to develop a statewide Children's Mental Health and Substance Abuse delivery system. This issue has also been addressed within SIG in the form of researching and encouraging the use of evidence based therapeutic practices and workforce development. This also includes education to the medical field as we know that many prescriptions are distributed via family care physicians, especially in rural areas where there is a shortage of psychiatrists. This Division can specifically address the practitioners we fund for services and are working in collaboration with the Divisions of Medicaid/Long Term Care and

Children/Family Services to address appropriate service application. Much consideration is given to the recommendation of the Committee as to continue the planning of this domain for future implementation.

In October 2004, Nebraska Department of Health and Human Services was awarded a U.S. Department of Health & Human Services - Substance Abuse & Mental Health Services Administration (SAMHSA) State Infrastructure Grant to develop a statewide Children's Mental Health and Substance Abuse delivery system. This is a five year grant at $750,000 per year. This upcoming federal cycle impacting 2009 will be the fifth and last year of this grant project. This funding has been utilized for infrastructure capacity building and system development. This State Infrastructure Grant (SIG) has addressed many challenges to the system.

The Committee Asked

Recommend the Division to inform the committee member on what is the hiring process for the Officer of Consumer Affairs and will there be a National search of applicants.

Division of Behavioral Health Response

Diana Waggoner of the Kim Foundation is chairing the search committee. Dan Powers contacted the three Consumer Technical Assistance centers(National Empowerment Center, CONTAC and National Self-help Clearinghouse) and asked them to post job announcement on their website. In addition Dan sent the announcement out to National Association of Consumer/Survivor Mental Health Administrators listserve. He also contacted Mindfreedom a national consumer organization and they sent job announcement out to membership.

To date, 28 applications have been received. The review team consists of consumers outside the Division of Behavioral Health, Dr. Blaine Shaffer, and representatives from the DHHS Human Resources & Development.

Here is the job announcement.

Administrator - Consumer Affairs #255-28029; NSOB-3rd Floor-Lincoln; Salary: Negotiable based on experience. Full-time, M-F, 8-5.

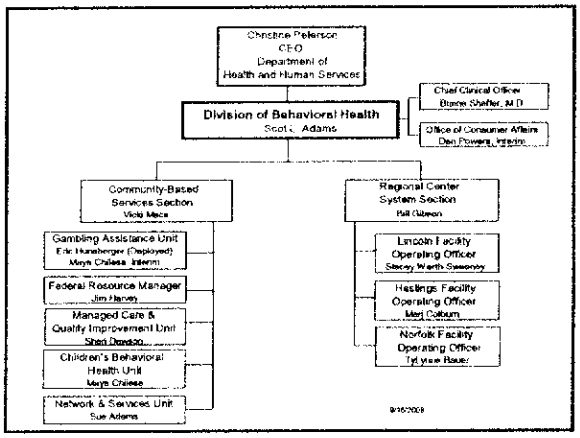
Under administrative supervision of the Director of the Division of Behavioral Health Manage the Office of Consumer Affairs, develop plans and processes for working in close collaboration with consumers of substance abuse, mental health and gambling services and their families. Advocate for consumer views and achieve the meaningful involvement and participation of consumers as a priority in the state funded behavioral health system; provide comments on proposed regulations and rule changes, develop with Ombudsman and others a fair and equitable consumer grievance system; track complaints and write reports; collect and analyze complaint data. Actively support, expand and develop a plan for consumer participation. Manage federal and other grant projects. Provide

supervision and direct the work activities of assigned staff. Train or manage training consumers to take meaningful roles throughout the behavioral health system. Monitor, encourage and develop regional consumer specialists. Encourage relevant and useful consumer participation in behavioral health emergency system. REQUIREMENTS: Bachelors degree with progressively responsible experience that involve consumer related issues. Must be current or former consumer of behavioral health services and have specialized knowledge, experience or expertise in substance abuse, mental health or gambling services with recovery and willing to disclose this publicly. Supervisory experience required. Experience with grant projects. Excellent communication skills. Ability to analyze, help resolve problems, interpret laws, regulations and procedures.

CLOSING DATE: OPEN UNTIL FILLED.

Division of Behavioral Health

Scot Adams, Ph.D, Director



Guiding Principles for Behavioral Health

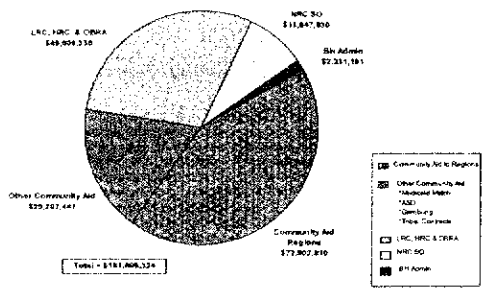
- We believe that wellness and recovery are possible.
- We believe safety, dignity and recovery are real.

People served in the community

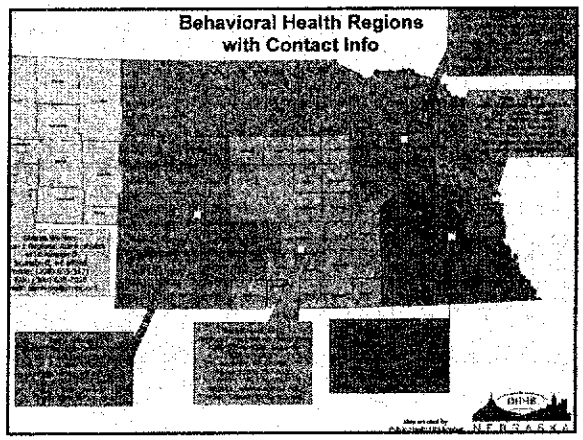
	FY 2004	FY 2008
Mental Health	13,567	35,694
Substance Abuse	19,557	19,685
Totals	33,124	48,018

Note: Some individuals may have a dual diagnosis and be receiving both types of services, but the count is unduplicated.

FY09 Behavioral Health Appropriation



Behavioral Health Regions with Contact Info



Progress – Behavioral Health

- Facilitated Consumer Participation into the System
  - Regional Consumer meetings
  - Office of Consumer Affairs
  - Regional Consumer Specialists
- Improved Safety at Regional Centers
  - Installed cameras at LRC in February, 2008
  - Increased safety procedures
  - Worked with the Department of Correctional Services on safety interventions
  - Visited with other states
  - External experts engaged
  - Decreased incidents of violence

Progress – Behavioral Health

- Established the Office of Children's Behavioral Health.
- Jointly submitted the LB 542 plan for behavioral health services for children and adolescents on time on January 4, 2008.
- Increased Housing Related Assistance
  - 127 people received in FY 2006; 557 in FY 2007 and 717 in FY 2008.

Progress – Behavioral Health

- Completed the Emergency Protective Custody Regional meetings.
  - Improved understanding of system
  - Refined procedures
  - Decreased EPCs
  - Increased Mobile Crisis Team utilization
- Established Trauma Informed Network
- Managed LB 95 Medications
- Improved Network of Care

Challenges – Behavioral Health

- Forensic psychiatric services
  - Evaluation
  - Restoration
  - Treatment
- Coordinating emergency access
- Special Populations of people
  - Persons with Developmental Disabilities
  - Older adults
  - Transitional age youth
  - Persons in Assisted Living facilities
- Fully integrating mental health and substance abuse into Behavioral Health

Attachment 4

NE Transformation Transfer Initiative Application

Maximizing Consumer and Family Voice at All Levels

From: Nebraska Department of Health and Human Services
Division of Behavioral Health
Scot L. Adams, Ph.D., Director

Transformation Readiness

Nebraska has made significant progress under Behavioral Health Reform. Since 2004, Nebraska has been working to create more community-based behavioral health services, so people can be served closer to their homes and families. Reform of Nebraska's behavioral health system was created by LB 1083, passed in 2004. LB 1083 reform focused on increasing access to community-based care, moving people from Regional Centers to local care, and preventing people from being institutionalized whenever appropriate. $30.1 million was moved from the Hastings and Norfolk Regional Centers (state operated psychiatric hospitals) to community services. "We've made good on our promise and actually delivered for community services," said Scot Adams, Director of the Division of Behavioral Health. The '1083' phase of Nebraska Behavioral Health Reform is now completed. Time has come for the next steps.

Building on current reform efforts, the Division of Behavioral Health, as the chief behavioral health authority for the State [Nebraska Behavioral Health Services Act / 71-806(1)], believes an effective strategy will be to take the next steps on developing Peer Support. Peer Specialists need to be part of the next chapter in Nebraska's BH Reform moving from a focus on the individual's illness to one that focuses on the person's strength. Recovery is no longer only about what clinicians do to consumers. It has become, with the assistance of the Peer Specialist, what consumers do for themselves and each other. This also means the Peer Specialist provides hope, as a role model, that recovery is a real possibility.

Transformation Initiatives Already Underway and Leveraging the TTI Award

As part of transforming the mental health system, Nebraska has devoted substantial resources and effort to improving consumer participation in service delivery and policy development. These State resources and infrastructure provide a foundation to effectively leverage the Transformation Transfer Initiative (TTI) award funds for the proposed initiative. The existing initiatives include but are not limited to:

- The Nebraska Behavioral Health Services Act [71-805(2)] established the Office of Consumer Affairs within the Division. This Office is responsible for promoting consumer and family involvement across the state.
- The Division of Behavioral Health allocated funding to contract with each of the six Regional Behavioral Health Authorities for consumer specialist positions (in one region the position is actually shared by two consumers). In State Fiscal Year 2009, there is **$412,055 in state funds** supporting these Regional Consumer Specialists. The Division expects each Region to address the Consumer and Family Involvement issues: 1. Policy and Regulation Development; 2. Program Planning, including Needs Assessment; Development And Delivery; 3. Training And Technical Support; 4. Financial Planning and 5. Complaints and Grievances.
- The Division funds consumer and family organizations including National Alliance for the Mentally Ill –Nebraska ($46,650); Mental Health Association of Nebraska ($46,650); Partners in Recovery ($46,650 for substance abuse consumers); and League of Human Dignity ($15,000 for cash advances and reimbursements to consumers in order to help people attend meetings). In addition, the Division of Behavioral Health provides $36,000 to the Division of Children & Family Services to help support the Nebraska Federation of Families and its six local affiliates.

- For years, the Division has used the five percent (5%) administrative set aside from the Federal Community Mental Health Services Block Grant to help support two state Consumer Liaisons & Annual Consumer Conference ($98,695).

Proposed Initiatives Rooted In Systems Change

With all of these efforts underway, there remains work to be done. In the Nebraska FY2009 Application for the Federal Community Mental Health Services Block Grant included under "2. Unmet Service Needs" GAP #1: CONSUMER INVOLVEMENT. This proposal is intended to directly address the concerns expressed under this GAP. The Division of Behavioral Health will contract with University of Nebraska Public Policy Center and a qualified organization to do peer support training. The initiatives will include:

University of Nebraska Public Policy Center (UNPPC) will do the following:

A. Administer a competitive bid process to select a qualified organization to provide Peer Support Training in Nebraska. The bid process product will be a ranking of qualified bidders and a rational for selecting a contractor to be completed by April 1, 2009.
B. Complete an evaluation of the Peer Support Training including but is not limited to the development and administration of a strategy involving a pre-test, and post-test of consumers attending the training, data analysis and reporting of results.
C. Complete an analysis on what other states are doing in the Peer Support area,
D. Complete a comprehensive literature review on peer support

The Peer Support Training contactor will do the following:

A. Provide consultation to the Division on the next steps involved in the implementation of Peer Support in Nebraska. The consultation is to include, but is not limited to how to establish a sustainable statewide Peer Support programs, and related areas.
B. From May 2009 to July 2009, hold between three up to six Peer Support Training sessions across the state. Each training session will use the an approved Peer Support Training curriculum. The Regional Consumer Specialist in each Region will work to organize these classes. This Peer Support Training should cover topics such as understanding the role of peer support within the Nebraska Behavioral Health System; how the Wellness Recovery Action Plan (WRAP) developed by Mary Ellen Copeland helps to support a consumer's recovery; how to establish a working relationship with consumers, how to encourage independence, and how advocate for others.
C. Complete one Train the Trainer session in July 2009 with consumers who can teach the curriculum (one or two consumers per Region as approved by the Regional Consumer Specialist and the Office of Consumer Affairs)
D. By September 1, 2008, the contractor will be responsible for a complete report covering the training across the state, train the trainer, and other aspects of the project

Both UNPPC and the Peer Support Training Contractor will do the following:

A. Provide a brief progress report to the State Advisory Committee on Mental Health Services at the meetings scheduled for February 5, 2009; May 7, 2009; and August 13, 2009.
B. hold a statewide meeting in August 2009 sharing the results of this Peer Support project
C. Make recommendations to the Division on the role for peer specialists within the Behavioral Health workforce in Nebraska.

Collaborating Agencies.
These groups and their subcommittees include representation from consumers, family members, service providers, state and regional behavioral health authorities (mental health and substance abuse), Medicaid, public health, criminal justice, community corrections, vocational rehabilitation, housing, advocacy organizations, and elected officials.

- Division of Behavioral Health will contract with the University of Nebraska Public Policy Center (PPC) to take the next steps in developing a statewide sustainable Peer Support program.
- Six Regional Behavioral Health Authorities (including the Regional Consumer Specialists)
- The State Advisory Committee on Mental Health Services, the State Advisory Committee on Substance Abuse Services, and the Behavioral Health Oversight Commission.
- National Alliance for the Mentally Ill --Nebraska, Mental Health Association of Nebraska, Partners in Recovery, and League of Human Dignity, and the Nebraska Federation of Families and its six local affiliates.

Consumer Involvement in Planning and Implementation.
The Office of Consumer Affairs and the Regional Consumer Specialists will be actively involved in this project from start to finish. NOTE: At this time, the Division of Behavioral Health is recruiting for the next Administrator for the Office of Consumer Affairs. At this time, Dan Powers is serving as the interim Administrator.

Measurable Outcomes - The University of Nebraska Public Policy Center and the Peer Support Contractor will provide a complete report to the Division of Behavioral Health on all work completed under this Transformation Transfer Initiative including used of a competitive bid process to select a qualified organization to provide Peer Support Training; an evaluation of the Peer Support Training as well as the Train-the-Trainer; an analysis on what other states are doing in the Peer Support area, a comprehensive literature review on peer support, a statewide meeting in August 2009 sharing the results of this Peer Support project, and recommendations to the Division on statewide standards for recognizing peer specialists within the BH workforce in NE.

Projected Budget. Use of Federal Funds

f. Contractual to: -- University of Nebraska Public Policy Center ($50,000) -- Peer Support Training contractor ($160,000).	$210,000
j. Indirect Charges (5% administrative cost)	$11,000
k. TOTALS	$221,000

On November 4, 2008, the State Advisory Committee on Mental Health Services, which serves as the State Mental Health Planning Council under the Federal Community Mental Health Services Block Grant reviewed this proposal. This Committee made the following recommendation:

II. Initiative Timeline

Activities	Timeline	Who	Outcome
Proposal submitted to NASMHPD	*November 7, 2008*	Division of Behavioral Health	Proposal submitted
NE receives TTI award	*Early December 2008*	announced by CMHS	NE funded
Division of Behavioral Health contracts with University of Nebraska Public Policy Center	January 2009	Division of Behavioral Health	Signed contract
UNPPC completes the bid process	April 1, 2009	UNPPC	List of qualified contractors to complete the Peer Support Training
Division of Behavioral Health contracts with peer support training contractor.	April 2009	Division of Behavioral Health	Signed contract
Contractor conducts peer support training for consumers from across the State of Nebraska.	May 2009 to July 2009	Contractor, DBH Office of Consumer Affairs & six Rg Consumer Specialists	Consumers trained on peer support
UNPPC and contractor provides a progress report to the State Advisory Committee on MH Services	February 5, May 7 and Aug 13, 2009	UNPPC, Contractor and the State Advisory Committee on MH Services.	State Advisory Committee on MH Services informed on the progress of the project.
Peer Support Training Contractor conducts train the trainer	July 2009	Contractor, DBH Office of Consumer Affairs & six Rg Consumer Specialists	Consumers trained to teach peer support
UNPPC and Peer Support Training Contractor holds a statewide meeting on Peer Support	August 2009	Nebraska Behavioral Health System	Nebraska stakeholders learn more about peer support.
UNPPC and Peer Support Training Contractor report to Division on the project.	Due September 1, 2009	UNPPC and Peer Support Training Contractor	One comprehensive report
completed and final reports	*September 15, 2009*	Division of Behavioral Health	submitted to NASMHPD

III. Initiative Coordinator

Jim Harvey from the Division of Behavioral Health will be the coordinator and contact person for the TTI initiative.

Jim Harvey
Nebraska Department of Health and Human Services / Division of Behavioral Health
301 Centennial Mall South, Third Floor, PO Box 98925, Lincoln, NE 68509
phone 402-471-7824 email : Jim.Harvey@nebraska.gov

Quality Improvement is not intended to assign blame.
It is a process of exploring issues, asking questions, learning together and making improvements.

As you know, Medicaid, CFS and DBH entered into a 2 year contract with Magellan on July 1, 2008. We continue to work on building effective working relationships with all contract and DHHS partners. It is essential we obtain data to manage our system in order to achieve positive consumer outcomes.

DBH continues to work towards implementing a data-driven approach to managing the service system. This development and implementation process takes collaboration, ongoing communication and perseverance.

In our RFP, we requested participation in the vendor's Quality Improvement Committee knowing that this committee would be the catalyst for improving our system. Sharyn Wohlers, Ingrid Gansebom, Joel McCleary, Linda Wittmuss and Sheri Dawson were initially identified as participants. Following an initial meeting there were several internal discussions. It was determined that DBH would establish the M-QIT (Magellan Partnership Quality Improvement Team).

Goals of the Team include:

- Improving communication and coordination between the Division, Regions, Providers and Magellan
- Developing an understanding of the work flows, systems and processes related to data and making recommendations for improvement
- Establishing a mechanism for the identification, review and resolution of issues
- Reviewing reports and recommending content and format improvements to ensure the presentation of meaningful data

The Division wants a broad representation of providers, regions, consumers and other who would be critical in assisting with this improvement process. The Division was thoughtful in making the following selection for participants to serve during the contract period:

- Region 1 –Sharyn Wohlers, Regional Administration
- Region 2 –Karen Weston, Alicia Odean, Great Plains Hospital, Kathy Seacrest, Region 2
- Region 3 –Melinda Farritor , Director of Network Services
- Region 4 –Ingrid Gansebom, Regional Administration
- Region 5 –Dean Settles, Lancaster Community Mental Health Center
- Region 6 –Laurie Houseworth, Catholic Charities and Sharon Rathbun, Region 6
- Family Federation –Candy Kennedy
- Dan Powers, DBH Office of Consumer Affairs
- Magellan Representatives –Kathy Dinges, Lisa Christensen, Kaila Mailahn, Don Reding, Carl Chrisman, Becky Braymen
- DBH Representatives –Sheri Dawson facilitator, Vicki Maca, Robert Bussard,
- Linda Wittmuss (ASO Transition Contractor)
- Stacey Werth-Sweeney, Lincoln Regional Center

Current info

LRC Capacity/Census

	Capacity 90	Census (76) 11/4/08
Region 1	4	5
Region 2	4	0
Region 3	9	4
Region 4	9	5
Region 5	35	38
Region 6	29	24

Regional Center Referral List
Emergency System
Presentation
for
State Advisory Committee on Mental Health Services

November 4, 2008
By
Mary O'Hare, Consultant
402-326-1124

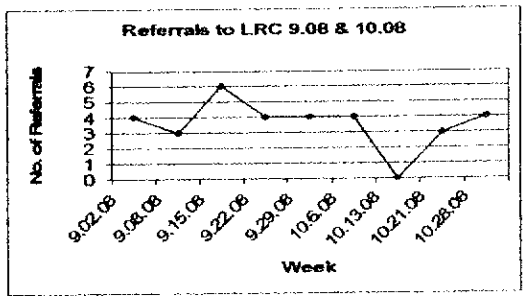
LRC Capacity

Region	Capacity (100)
Typical Census	85
Region 1	4
Region 2	5
Region 3	10
Region 4	10
Region 5	38
Region 6	33

NRC Mental Health Unit

Region	# of Persons Served at NRC (Capacity-29)
Region 1	0
Region 2	0
Region 3	3
Region 4	6
Region 5	3
Region 6	15

Referral List to LRC



Improved Community Services Needed

- Community Services for Individuals with **TBI**
- Community Services for Individuals with **Nursing Home Needs**
- Community Services for Individuals with Dual Diagnosis of **Intellectual Disabilities** and Mental Illness
- Community Services for Individuals with 'Not Responsible for Reasons of Insanity' **NRRI** status5
- Community Services for Individuals with **Refractory Symtomatology**

Emergency Community System (ECS) **Supports**

3 Support Components

1. **Primary Support**
2. **Secondary Support**
3. **Tertiary Support**

ECS Support Components

1. **Primary Supports** are preventative in nature and designed to head off a crisis before it results in the involvement of law enforcement and a subsequent emergency protective custody hold.

   - Examples: Crisis Response Teams, Crisis Respite, WRAP Training, Emergency Community Supports

ECS Support Components

2. **Secondary Supports** are crisis oriented and designed to provide the appropriate level of support from the point of legal involvement such as an EPC, custody warrant, or a mental health board commitment to the point of dismissal from the legal system.

   - Examples: Crisis Centers, Acute or Subacute Hospitals, LRC

ECS Support Components

3. **Tertiary Supports** are based in a relapse prevention model and designed to promote recovery following a psychiatric crisis through efforts such as WRAP training sessions and specially designed supports such as Emergency Community Support.
   - Examples: Peer Support, Safety Plans, WRAP Plans, Support Groups, Emergency Community Support

ECS Goals

- **Primary Support Goal**
  - Goal: The number of consumers who experience Emergency Protective Custody holds will decrease or maintain.
- **Secondary Support Goal**
  - Goal: The number of consumers committed inpatient by a mental health board will decrease.
- **Tertiary Support Goal**
  - Goal: The number of consumer who experience a repeat Emergency Protective Custody will decrease.

ECS Benchmarks

1) 62% of all consumers EPC'd are diverted from an outpatient or inpatient commitment.

2) 52% of Nebraska consumers EPC'd who require a commitment receive an outpatient rather than an inpatient commitment.

ECS Benchmarks

3) 81% or Nebraska consumers who are EPC'd have the EPC dropped or receive an outpatient commitment.

4) 29% of all consumers EPC'd are inpatient committed.

ECS Benchmarks

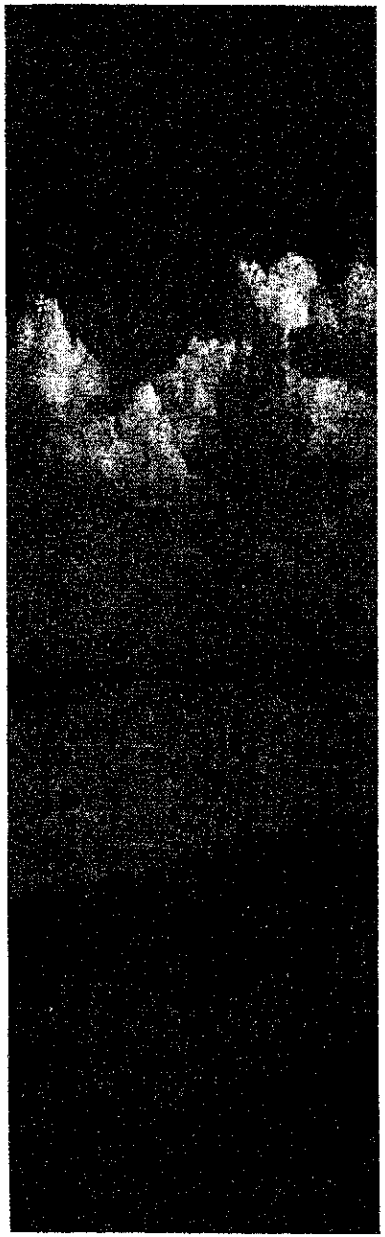
5) 14% of Nebraska consumers EPC'd are EPC'd more than one time in a 12-month period.

ECS Statewide Initiatives for 08-09

1. Improved community services for individuals needing nursing homes
2. Improved crisis response & law enforcement training & resources
3. Improved services for individuals with a dual diagnosis of intellectual disabilities and mental illness
4. Improved emergency community support services

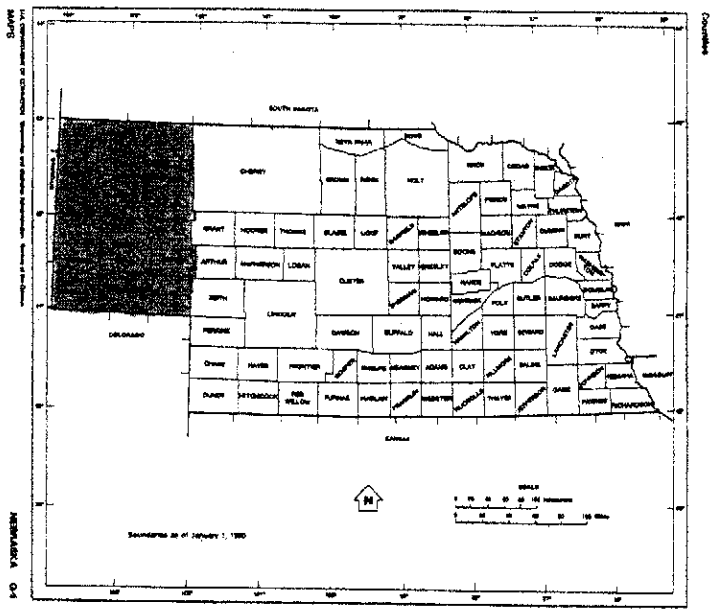
ECS Contacts

- Region 1. Calvin Prouty (308-672-4796)
- Region 2. Robyn Schultheiss (308-390-4645)
- Region 3. Beth Reynolds (308-440-9113)
- Region 4. Melinda Crippen (402-750-6172)
- Region 5. Kristin Nelson (402-890-4954)
- Region 6. Dennis Snook/Katie Hruska (402-444-7719)



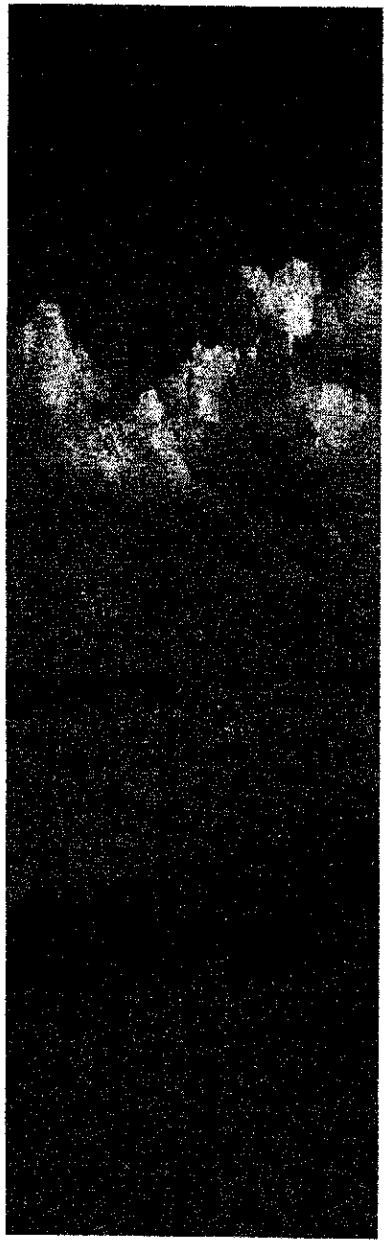
Region I Counties

- Banner
- Box Butte
- Cheyenne
- Dawes
- Deuel
- Garden
- Kimball
- Morrill
- Scotts Bluff
- Sheridan
- Sioux



85,862 People
15,000 Sq Miles

Attachment 7



1966

Formation of Panhandle Mental Health & Mental Retardation Facility under the Interlocal Cooperation Act

1974

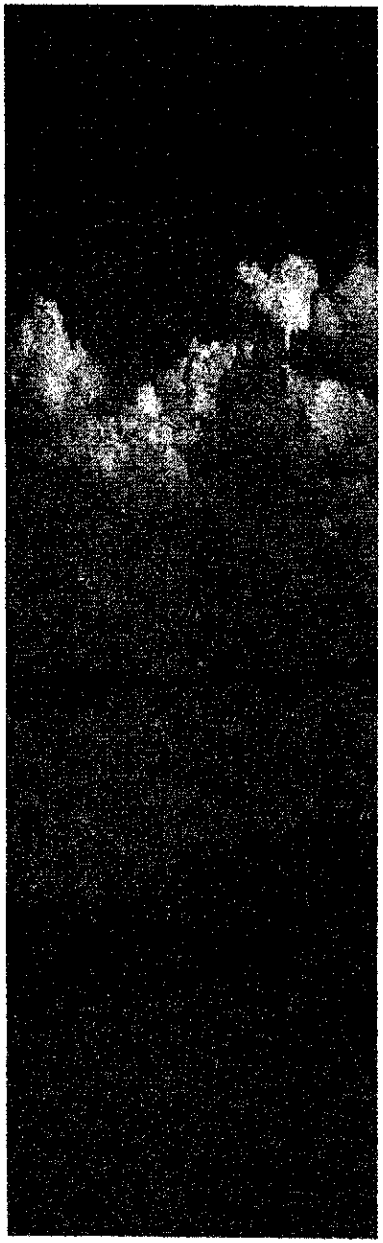
Formation of the Region I Community Mental Health Program under the Interlocal Cooperation Act

1974 - LB 302

The Nebraska Comprehensive Community Mental Health Services Act

1977 – LB 204

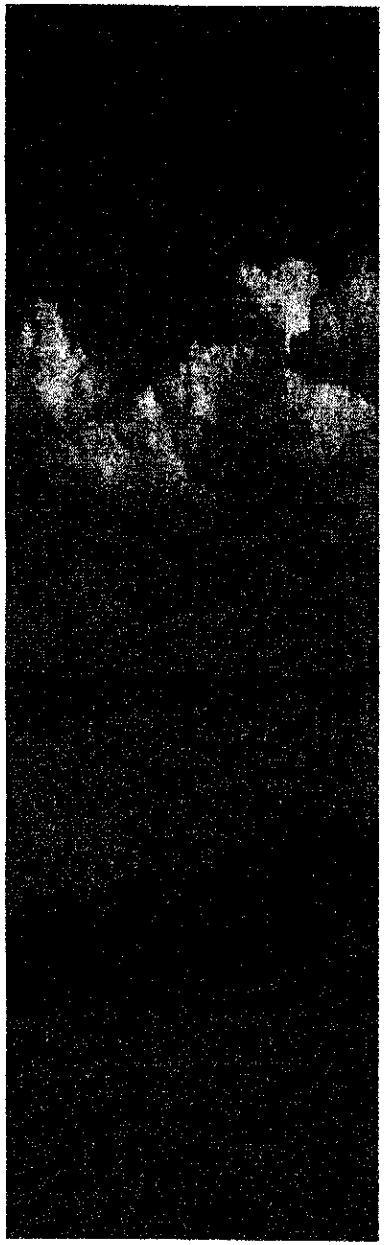
Substance Abuse Services were added.



Mission

Region I plans, coordinates, and develops capacity to create a balanced network of mental health and substance abuse services for both children and adults in the Panhandle.

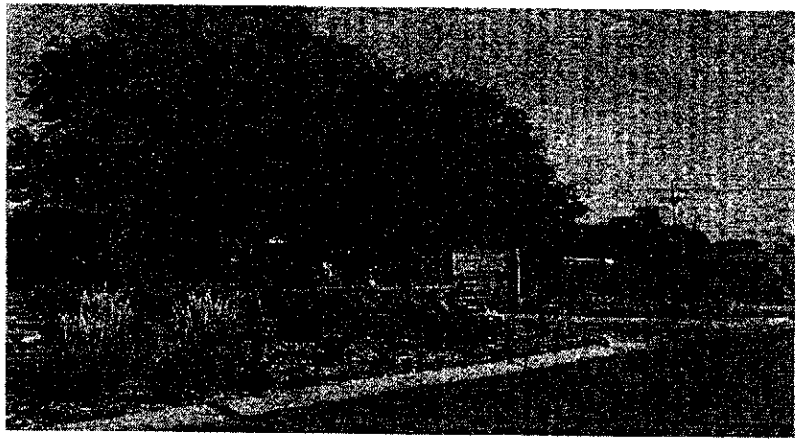
Region I provides opportunities for training and support, monitors programs for best practices, and works to integrate multiple disciplines and services.



Region I
Service Provider Network

1. Box Butte General Hospital
2. Chadron Community Hospital
3. Cirrus House
4. CrossRoads Counseling, LLC
5. Human Services, Inc.
6. North East Panhandle Substance Abuse Center (NEPSAC)
7. Panhandle Mental Health Center
8. Regional West Medical Center
9. Western Community Health Resources (WCHR)

Panhandle Mental Health Center



Scottsbluff, Alliance, Sidney and Chadron

MH & SA Outpatient

MH & SA Community Support

Medication Management

Intensive Outpatient SA

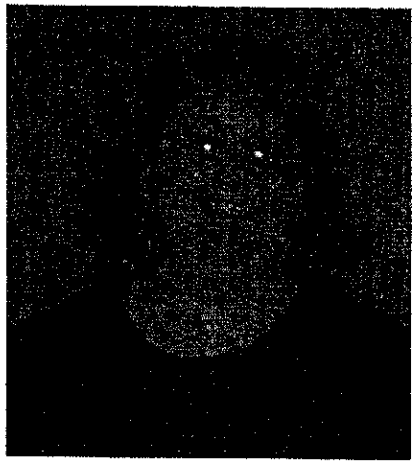
Program for Alternative Learning

Reach Out Foster Care

Emergency 24hr.Clinician/Phone

Psychological Testing

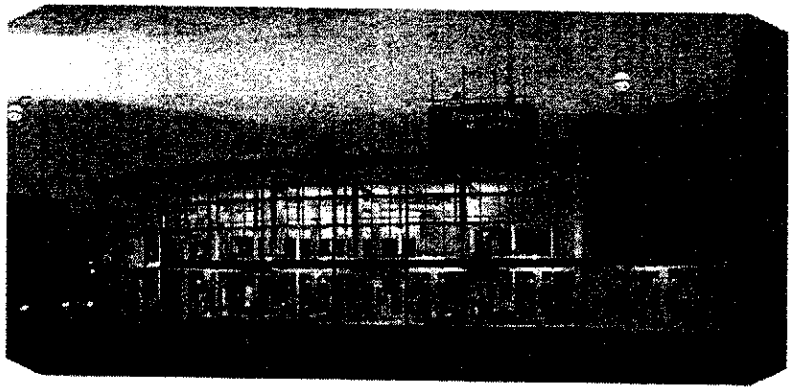
Sharyn Wohlers
Director



Dr. Pamela Richardson
Clinical Director

Regional West Medical Center

Scottsbluff, Nebraska



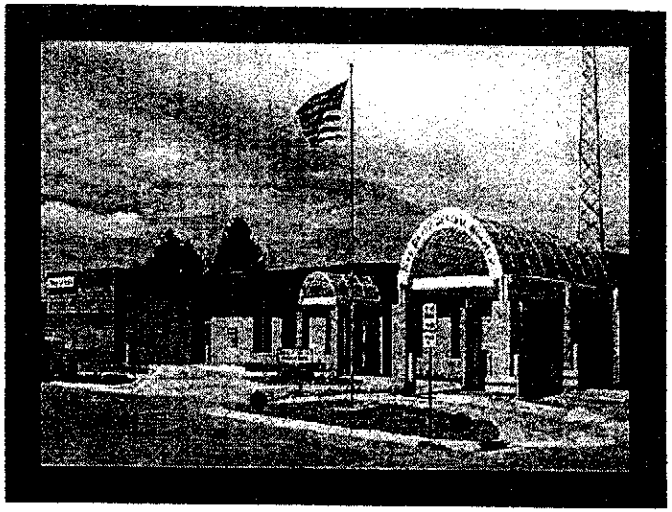
Homeward Bound:

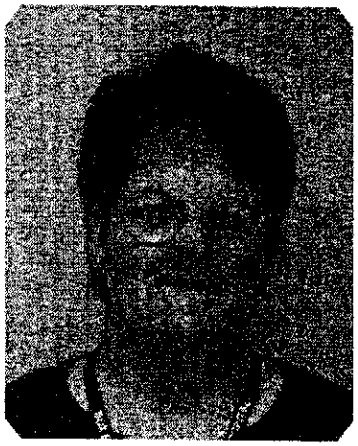
Acute & Subacute Inpatient Care

Dual Diagnosis Program

- Emergency Protective Custody (EPC)

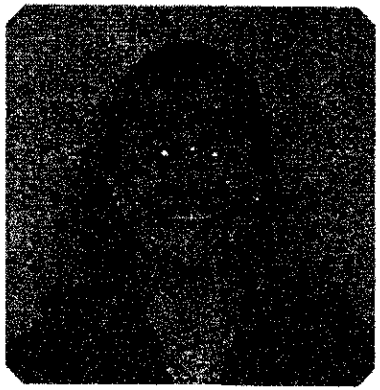
Box Butte General Hospital
Alliance, Nebraska



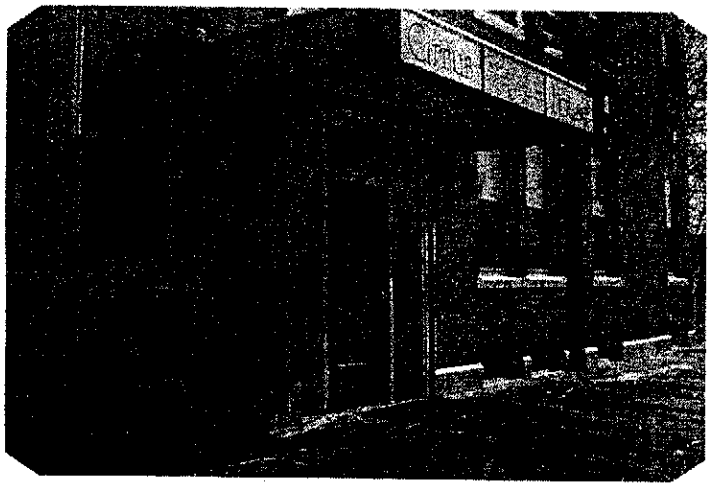


Mary Mockerman
Director of Special Services

- Emergency Crisis Assessment (23:59)
- Local Crisis Response Team
- Emergency Community Support



Christine Karell
Local Crisis Response Team Coordinator



Cirrus House

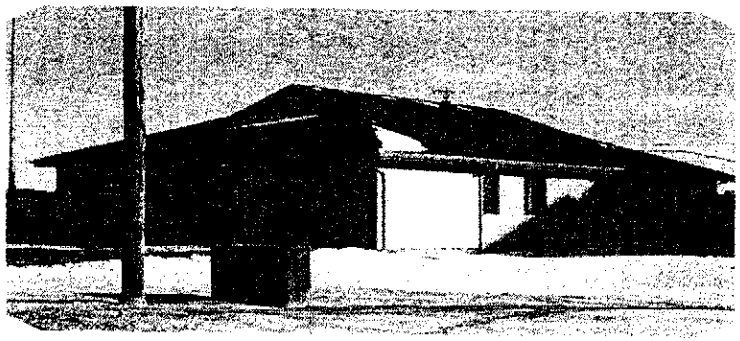
Scottsbluff, Nebraska

A clubhouse environment for adults with severe and persistent mental illness.

- Mental Health Community Support
- Day Rehabilitation
- Vocational Support
- Day Support
- Supported Employment
- Transitional Living
- Independent & Assisted Living
- Transition age Youth Community Support

Brent Anderson
Executive Director

Human Services, Inc.
Alliance & Scottsbluff



Glenda Day, Director

- Substance Abuse Community Support
- Social Setting Detox - Scottsbluff
- 24hr. Clinician Phone
- Short-term Residential
- Intensive Outpatient
- Substance Abuse Outpatient

NEPSAC

Northeast Panhandle Substance Abuse Center

Chadron & Gordon, Nebraska

Jane Morgan
Director

- Social Setting Detox
- Short-term Residential
- Outpatient Substance Abuse Services
- Community Support SA

70% of the consumers served by NEPSAC are Native American.

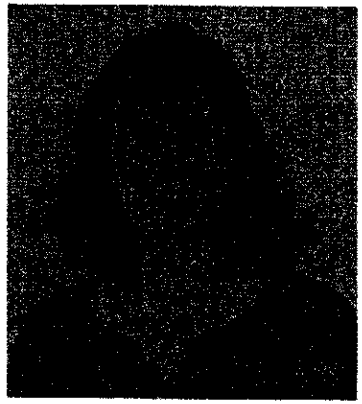
WCHR

Western Community Health Resources

Chadron, Nebraska

- Mental Health Community Support
- Transition Age Youth Community Support
- Peer Support

Sandy Roes,
Director



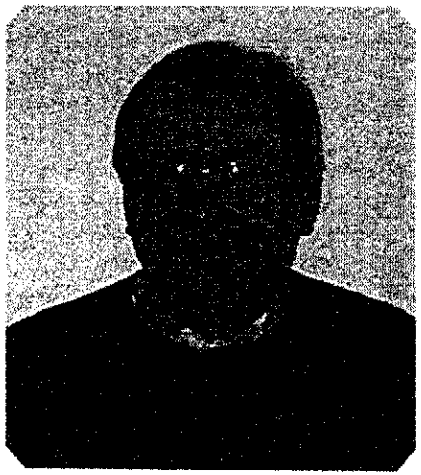
Keri Nelson,
Family Advocate
Director

CrossRoads Counseling, LLC
Chadron, Nebraska

- Local Crisis Response Team
- Emergency Community Support
- Outpatient Mental Health

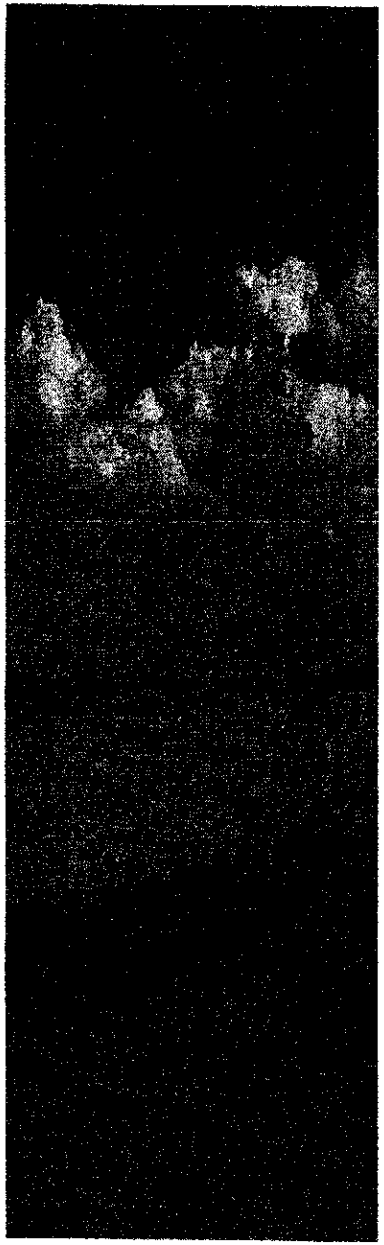
Cari Brunner
Coordinator

Chadron Community Hospital
Chadron, Nebraska



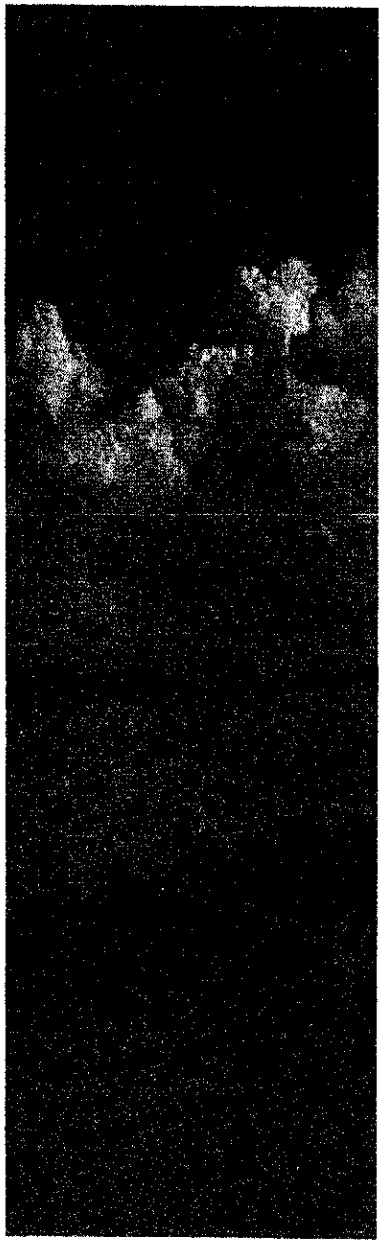
Harold Krueger, CEO

- Emergency Crisis Assessment (23:59)

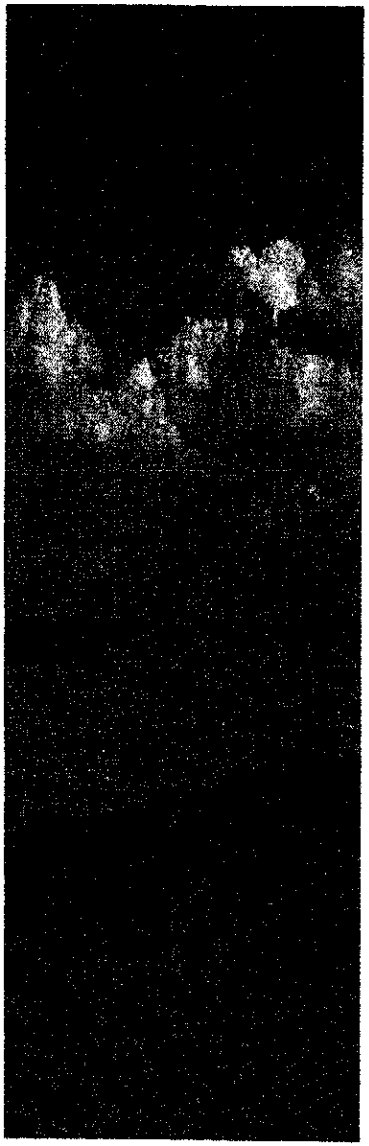


Services Provided by Region 1

- Professional Partner Program in Scottsbluff and Chadron
- ICCU – Integrated Care Coordination Unit
- Emergency Community Support
- Local Crisis Response Team for Scotts Bluff, Banner and Morrill Counties

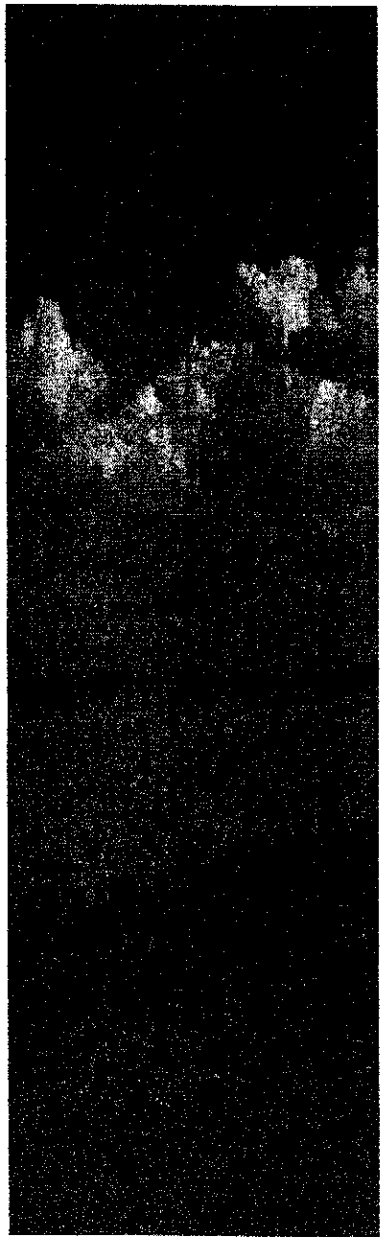


How has Behavioral Health Reform changed services in Region I?



Consumer Support & Coordination

- Two Consumer Empowerment Conferences in the last two years.
- Three WRAP trainers in Region I.
- 1275 contacts with consumers in FY08.
- RFP issued to develop three Peer Support positions in the Panhandle. One is in implementation stages, Two others to be developed by the Region.



Region I Reform Services

October 2005

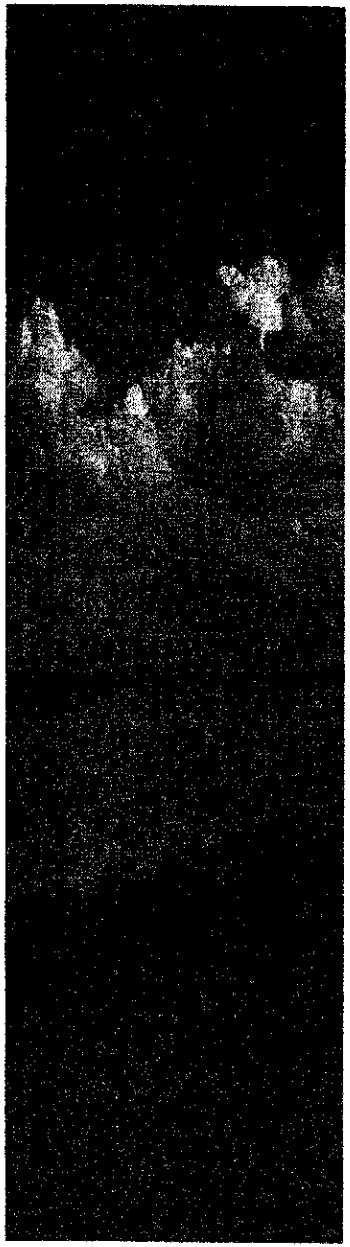
- Inpatient Dual Diagnosis program developed within the Homeward Bound program at RWMC.

June 1, 2006

- New LCRT in Scotts Bluff, Morrill, Banner Counties
  - 72 assessments in FY08
  - 59 of those were diverted from EPC

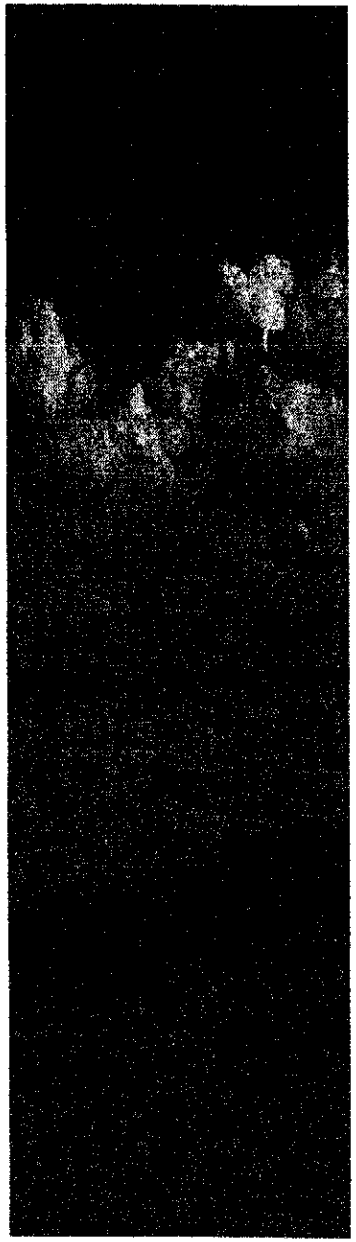
Region I Reform Services

- Additional Community Support services
  - Western Community Health Services in Chadron
  - Panhandle Mental Health Center in Scottsbluff
- Additional Medication Management services
  - Panhandle Mental Health Center in Scottsbluff
- Additional Short-term Residential services
  - Human Services in Alliance
  - NEPSAC in Gordon
  - Behavioral Health Services in Columbus



Region I Reform Services

- HART Housing Voucher Program with SBHA
  - Since inception, the program has operated at average 157% capacity.
- 8 Additional assisted living units for persons with mental illness (LB40A).
  - Cirrus House in Scottsbluff
- Increased funding for Acute & Secure Services
  - Homeward Bound Program at RWMC
- Expanded Emergency Community Support Program in Scotts Bluff, Banner, and Morrill Counties



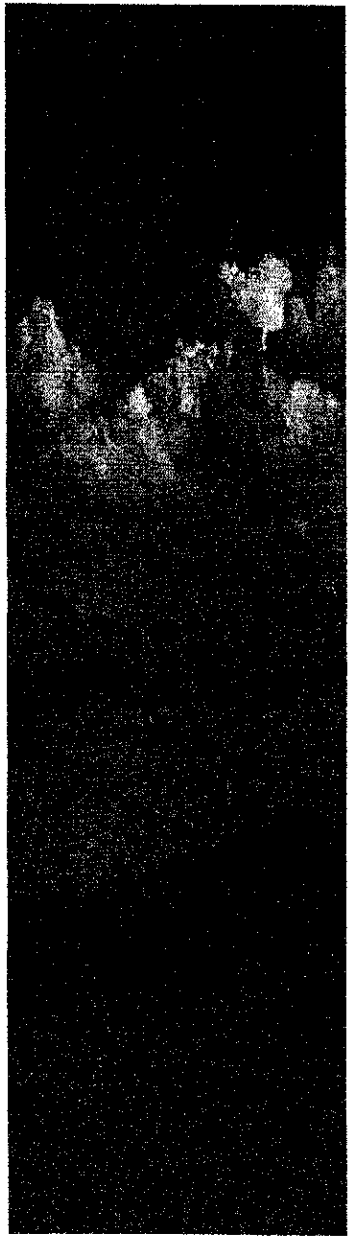
Services in Development
(On-going Funds)

Community Support for the Northern Panhandle

- **One full-time substance abuse worker**
- **One half-time worker for transition-age youth**

Community Support for the Mid-Section of the Panhandle

- **One half-time worker for transition-age youth**



Services in Development

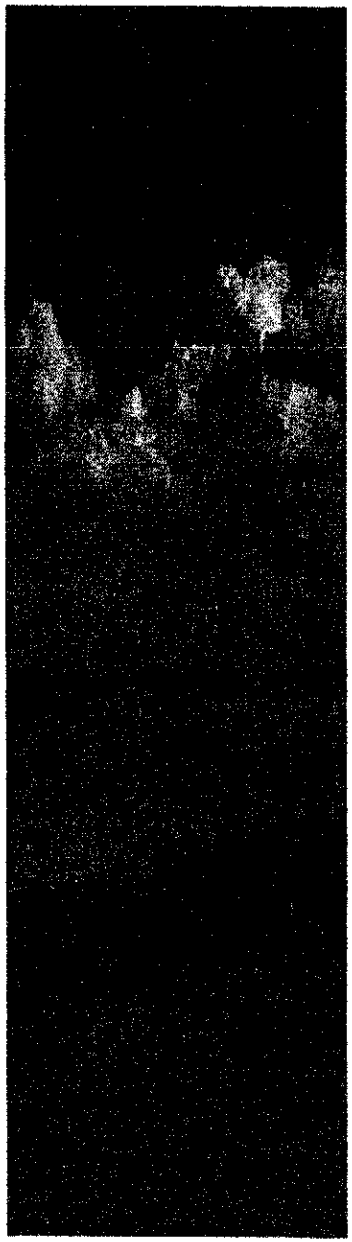
(On-going Funds)

Peer Support Services

- Three part-time peer support specialists

Long-term Care Project

Focus group was held on October 16, 2008 to collect input from area nursing homes regarding needs for staff training, consultation services, and other needs. Current barriers were identified and a "wish list" was developed. Additional meetings will be held to design services to help facilities manage behavioral health issues.



Services in Development

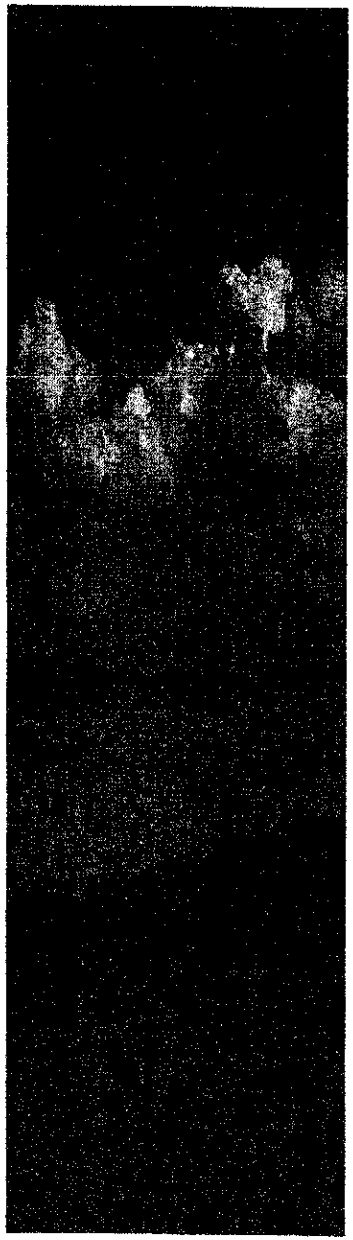
(On-going Funds)

WRAP Training Materials

- Region I has three WRAP trainers but additional funding is required for training materials. Expect to serve about 50 consumers each year.

Emergency System Focus Groups

- Plan for annual meetings to maintain contact with partners in the psychiatric emergency system and improve the system of care. Have identified a need to bring training to the partners rather than hold a centralized training.



Services in Development

(One-time Funds)

RFP will be issued by September 30, 2008, asking for proposals that address needs in at least one of the following categories:

- **Consumer Involvement**
- **Reduction of need for higher levels of care**
- **Relapse prevention services**
- **Workforce development**
- **Infrastructure development**
- **Pilot projects**

Proposals are due back November 4, 2008

DHHS
Nebraska Department of Health and Human Services
Division of Behavioral Health
State of Nebraska
Dave Heineman, Governor

October 10, 2008

Bev Ferguson, Chair
State Advisory Committee on Mental Health Services
3405 Portia Place
Norfolk, NE 68701

Dear Ms. Ferguson:

Last November, you had written the Governor about the loss of six positions within the Division of Behavioral Health in the Department of Health and Human Services.

Over the past year, the Division has been through several transitions and has been working on reorganizing staff and their duties. Because of these transitions, this caused delays in finalizing the organizational structure for the Division. We have now restructured positions and duties for all positions in this Division, which will strategically help with the workflow in this Division. These positions are budgeted.

I have attached an organizational chart for your use.

I apologize for this taking so long to respond, however, one thing led to another during the transitions and the positions were not finalized until very recently. Please feel free to contact me if you have any questions about these changes.

Thanking you for your support of our mission to help people build better lives, I am

Very truly yours,

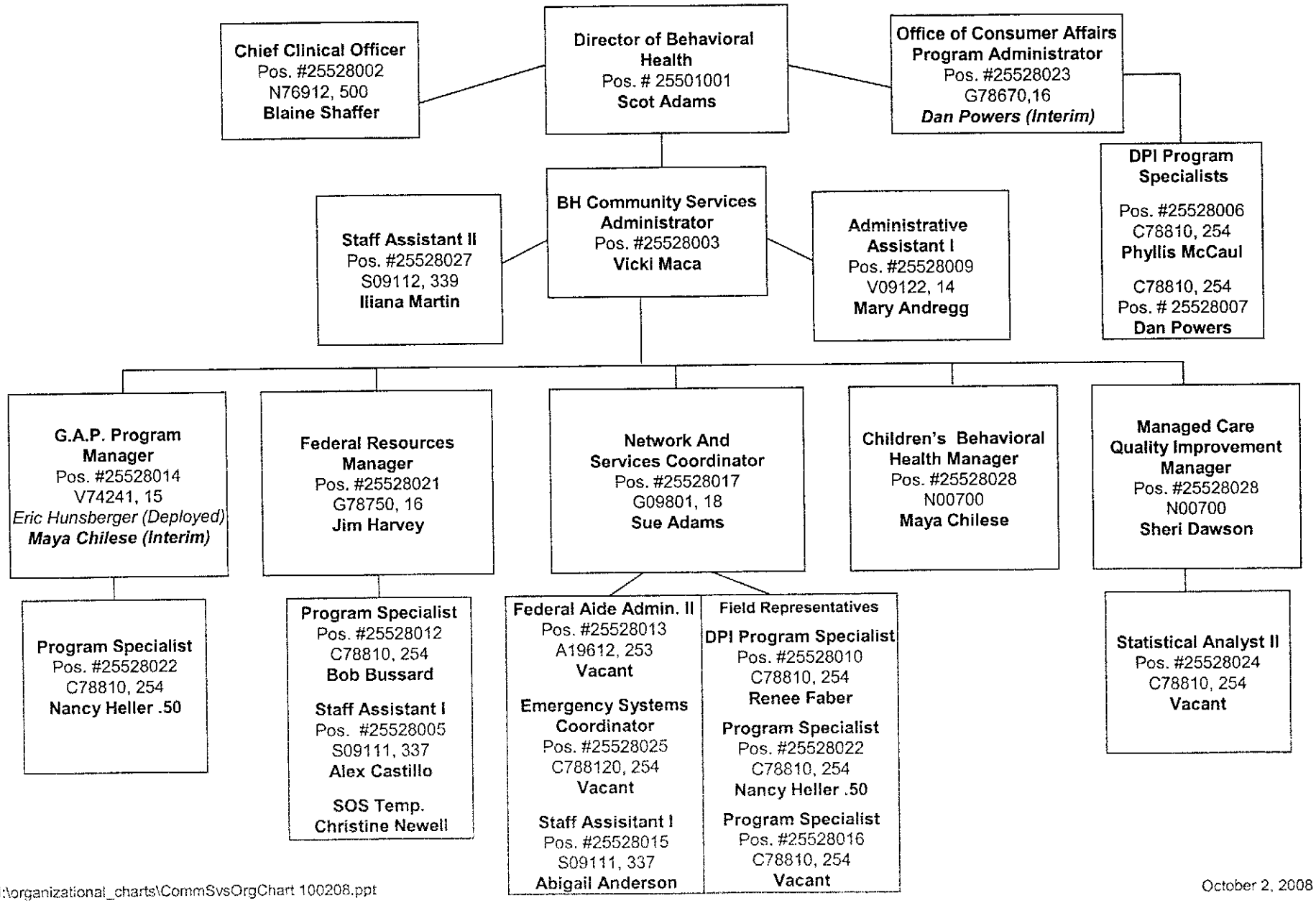
Scot L. Adams, Ph.D., Director
Division of Behavioral Health
Department of Health and Human Services

Thanks for your interest & support!
Scott

SLA/kjo

cc: Governor Heineman
Vicki Maca
Jim Harvey

Division of Behavioral Health
Community Services Section



State Advisory Committee on Mental Health Services

November 13, 2007

- HHS to draft
- Gov., Larry + PRO-fyi
F- Personnel - HHS

Governor Dave Heineman
Office of the Governor
P.O. Box 94848
Lincoln, NE 68509-4848

Dear Governor Heineman,

At the November 6, 2007 meeting of the State Advisory Committee on Mental Health Services committee, the following issue was discussed and a motion was made and approved unanimously to address our concerns to you.

The State Advisory Committee on Mental Health Services is concerned with the loss of six (6) HHS Division of Behavioral Health Services positions. It is our understanding that these six positions were not filled although the vacancies existed prior to the adoption of LB296.

We believe these six positions are essential in providing the expertise and specialized knowledge in the areas of transformation and recovery for people with severe mental illness.

This loss of personnel creates an extreme hardship on the Division, especially considering their strong efforts to continue the transformation process as outlined by LB1083 and the President's New Freedom Commission report.

We urge you to fill these critical six positions. Thank you for your consideration.

Sincerely,

Bev Ferguson

Bev Ferguson
State Advisory Committee Chair
3405 Portia Place
Norfolk, NE 68701

cc: Scot Adams

Responsibilities

Review Panel

- Present a concise, oral summary of each application through a comprehensive critique, highlighting the strengths and challenges related to each criterion, the material regarding the Mental Health Planning Council, and overall evaluation of the application, suggested recommended action(s) for each criterion, and other requirements as appropriate.
- After presentations by the secondary reviewers and other panelists, make a motion recommending an action of "Approved" or "Approved with written modification," for the application being reviewed and provide rationale for the motion.

State Designee

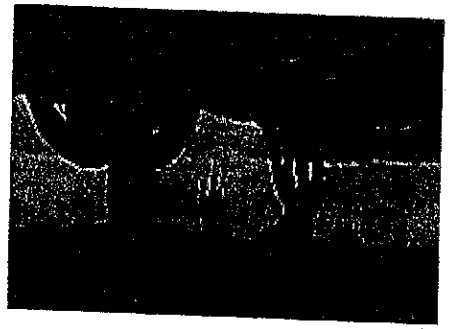
- Present an oral (and written) overview of the primary mental health issues within the State.
- Respond to questions posed by the review panel.
- Provide clarifications of issues as needed or requested.

MHPC Designee

- Present an oral (and written) overview of the status of the State's mental health system and the involvement of the Mental Health Planning Council.
- Respond to questions from the review panel.
- Provide clarification of Mental Health Planning Council recommendations as requested.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Community Mental Health Services Block Grant
Consultative Peer Review Process



CMHS
Mental Health Block Grant
FY2009
Consultative Peer Review
Midwest Region

Renaissance Hotel
9495 W. Coyotes Blvd.
Glendale, Arizona 85305
623-937-3700

October 21-23, 2008

Attachment 9

Overview

The objective of the Mental Health Block Grant Law is to assist States in establishing, implementing, or expanding an organized, community-based system of care for adults with serious mental illness and children with serious emotional disturbance. To this end, States are required to submit a State Plan for Comprehensive Community Mental Health Services each fiscal year. The grant funds may be utilized to carry out the State Plan; to evaluate programs and services under the grants/contracts; and to carry out planning, administration, and educational activities related to providing services under the Plan. A grant may be made only if the plan addresses the five (5) consolidated criteria in the law and is approved by the Center for Mental Health Services (CMHS). CMHS also must determine the extent to which the State has implemented the Plan from the previous year.

In keeping with the congressional mandate that CMHS provide leadership for the Federal effort in funding comprehensive community mental health services for adults with serious mental illness and children with serious emotional disturbance, and to ensure compliance with the Community Mental Health Services Block Grant legislation, and Part B of Title XIX of the Public Health Service Act, the CMHS Mental Health Block Grant Program will conduct regional consultative peer reviews of the Fiscal Year (FY) 2009 grant applications. The regional consultative review model for this process provides an opportunity for dialogue among State designees, Mental Health Planning Council (MHPC) designees, reviewers, and program staff, and increases useful communications with States while assisting them in achieving approvable plans upon which awards are made.

Schedule

October 21, 2008

Morning

8:30am	South Dakota
10:15am	Nebraska

Afternoon

1:15pm	Illinois
3:00pm	West Virginia

♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦

October 22, 2008

Morning

8:30am	Michigan
10:15am	North Dakota

Afternoon

1:15pm	Indiana
3:00pm	Wisconsin

♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦

October 23, 2008

Morning

8:30am	Ohio
10:15am	Iowa

Afternoon

1:15pm	Minnesota

Overview

The objective of the Mental Health Block Grant Law is to assist States in establishing, implementing, or expanding an organized, community-based system of care for adults with serious mental illness and children with serious emotional disturbance. To this end, States are required to submit a State Plan for Comprehensive Community Mental Health Services each fiscal year. The grant funds may be utilized to carry out the State Plan; to evaluate programs and services under the grants/contracts; and to carry out planning, administration, and educational activities related to providing services under the Plan. A grant may be made only if the plan addresses the five (5) consolidated criteria in the law and is approved by the Center for Mental Health Services (CMHS). CMHS also must determine the extent to which the State has implemented the Plan from the previous year.

In keeping with the congressional mandate that CMHS provide leadership for the Federal effort in funding comprehensive community mental health services for adults with serious mental illness and children with serious emotional disturbance, and to ensure compliance with the Community Mental Health Services Block Grant legislation, and Part B of Title XIX of the Public Health Service Act, the CMHS Mental Health Block Grant Program will conduct regional consultative peer reviews of the Fiscal Year (FY) 2009 grant applications. The regional consultative review model for this process provides an opportunity for dialogue among State designees, Mental Health Planning Council (MHPC) designees, reviewers, and program staff, and increases useful communications with States while assisting them in achieving approvable plans upon which awards are made.

Schedule

October 21, 2008

Morning	
8:30am	South Dakota
10:15am	Nebraska
Afternoon	
1:15pm	Illinois
3:00pm	West Virginia

♦♦♦♦♦♦♦♦♦♦♦♦♦♦

October 22, 2008

Morning	
8:30am	Michigan
10:15am	North Dakota
Afternoon	
1:15pm	Indiana
3:00pm	Wisconsin

♦♦♦♦♦♦♦♦♦♦♦♦♦♦

October 23, 2008

Morning	
8:30am	Ohio
10:15am	Iowa
Afternoon	
1:15pm	Minnesota

FY 2009 CHILD PLAN

SUMMARY CHECKLIST

STATE: NEBRASKA

CRITERION	APPROVED	MODIFICATION RECOMMENDED
1	X	
2	X	
3	X	
4	X	
5	X	

REVIEWER'S RECOMMENDATION

APPROVED AS WRITTEN: ___X___

APPROVED WITH WRITTEN MODIFICATION: _____

STATE: NEBRASKA

LIST OF MODIFICATIONS TO CHILD PLAN:

STATE DESIGNEE: James A Harvey DATE: 10/21/08

MHPC DESIGNEE: Bev Argust DATE: 10/21/08

If written modifications are required, please upload into WebBGAS in the section of the plan titled "Upload Revisions for the Plan."

FY 2009 ADULT PLAN

SUMMARY CHECKLIST

STATE: NEBRASKA

CRITERION	APPROVED	MODIFICATION RECOMMENDED
1	X	
2	X	
3	N/A	
4	X	
5	X	

REVIEWER'S RECOMMENDATION

APPROVED AS WRITTEN: ___X___

APPROVED WITH WRITTEN MODIFICATION: _____

STATE: NEBRASKA

LIST OF MODIFICATIONS TO ADULT PLAN:

STATE DESIGNEE: James A Haney DATE: 10/21/08

MHPC DESIGNEE: Bev Stigliano DATE: 10/21/2008

If written modifications are required, please upload into WebBGAS in the section of the plan titled "Upload Revisions for the Plan."

DRAFT

NEBRASKA
FY 2008 - STATE IMPLEMENTATION REPORT
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

(draft as of 10-24-2008)

For the U.S. Department of Health & Human Services
Substance Abuse & Mental Health Services Administration (SAMHSA)
Center for Mental Health Services (CMHS)
Division of State and Community Systems Development

Table of Contents

Neither the Implementation Report Indicators nor the Uniform Reporting System Tables are available for review at this time.

DRAFT

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

NOTE TO COMMITTEE: THIS TEXT WAS ALSO IN THE FY2009 APPLICATION. ONLY NEW CONTENT IS ON PAGE 18.

Adult - Summary of Areas Previously Identified by State as Needing Improvement
Narrative Question:
Adult - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

Here is a summary of the Adult areas previously identified by the NE Division of Behavioral Health as needing attention in the FY2008 Community Mental Health Services Block Grant application.

GAPS Section 2008

GAP #1: THE PREVALENCE OF MENTAL ILLNESS AND NUMBER OF INDIVIDUALS SERVED BY SYSTEM.
GAP #2: INFORMATION SYSTEM IMPROVEMENT
GAP #3: SHORTAGE OF STAFF
GAP #4: MEDICATION ACCESS
GAP #5: CULTURALLY COMPETENT SERVICES
GAP #6: MENTALLY ILL INMATES DISCHARGING FROM THE STATE CORRECTIONAL SYSTEM

Child - Summary of Areas Previously Identified by State as Needing Improvement
Narrative Question:

Child - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

Here is a summary of the Child areas previously identified by the NE Division of Behavioral Health as needing attention in the FY2008 Community Mental Health Services Block Grant application.

The State of Nebraska has identified several critical issues facing the behavioral health system. This system for children is multifaceted, fragmented and complex. "System" as used here means the statewide patchwork of persons and organizations that currently provide services and supports to children with behavioral health disorders and their families. Differences in policies and regulations within the State Divisions often create challenges in accessing and coordinating services. The existence of multiple 'systems' has led in many instances to significant fragmentation and inefficient service delivery, causing hardship for children and families. In addition, Nebraska is primarily a rural/frontier state which impacts access due to lack of appropriate services, workforce shortage and distance. Besides infrastructure concerns, there are challenges due to increasing diversity and the application of culturally appropriate care. Another previously identified area of attention was in the utilization of evidence based practices as well as family-centered services. However, special concern had been focused on three categories: transition aged youth, youth with co-occurring disorders and young children from birth through age five.

Adult - Recent Significant Achievements
Narrative Question:
Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Administrative Services Organization (ASO) contract

On February 1, 2008, the State of Nebraska, Administrative Services, Materiel Division, Purchasing Bureau, issued a Request for Proposal, RFP Number #2356Z1 for the purpose of selecting a qualified contractor to provide "Behavioral Health/Children and Family Services/Medicaid and Long-Term Care" Administrative Services Organization (ASO) [Request for Proposal 2356Z1].

The State of Nebraska was seeking a qualified contractor to provide a comprehensive ASO that will automate, manage, maintain, and coordinate the Mental Health and Substance Abuse treatment, Gambling Addictions and Child Welfare and Juvenile Services for the identified populations of the Behavioral Health, Children and Family Services, and Medicaid and Long-Term Care Divisions. The RFP release date was February 1, 2008. The bid opening date was April 1, 2008. On April 16, 2008, it was announced that Magellan Behavioral Health was selected as the Administrative Service Organization contractor for the Division of Behavioral Health, Division of Children & Family Services and the Division of Medicaid & Long Term Care. This contract ends on June 30, 2010. There are annual options for contract renewal for State Fiscal Years 2011, 2012 and 2013.

This Magellan Behavioral Health contract for Administrative Services Organization (ASO) covering the three DHHS Division of Behavioral Health, Division of Children & Family Services and Division of Medicaid & Long Term Care is a recent significant achievement. This should increase the level of coordination between these three Divisions. It does establish the possibility of reporting an unduplicated count of persons served receiving services across multiple systems funded by DHHS.

LB 1083 Behavioral Health Reform successfully completed

Four years of efforts to create more community-based behavioral health services, so people can be served closer to their homes and families, are paying off. Reform or change of Nebraska's behavioral health system was created by LB 1083, passed in 2004. LB 1083 reform focused on increasing access to community-based care, moving people from Regional Centers to local care, and preventing people from being institutionalized whenever appropriate.

It also promised to move $25.8 million from the Hastings and Norfolk Regional Centers to community services. "We've made good on our promise and actually delivered $30.1 million for community services," said Scot Adams, Director of the Division of Behavioral Health. "The '1083' phase of reform is now completed. We're moving forward to develop a strategic plan for the future of behavioral health care in our state."

LB 1083 Behavioral Health Reform
- The Promise: $25.8 M transferred from Regional Centers to Community Services
- Delivered: $30.1 M transferred from Regional Centers to Community Services

LB 1083 made these successes possible for people needing mental health or substance abuse services between July 2004 and June 2007:

- Greater consumer participation than ever before, with an Office of Consumer Affairs within DHHS and a consumer specialist in each local region
- 9,000 new consumers served closer to home (from 33,124 people served in FY 04 to 42,915 served in FY 07)
- More people served in community hospitals and fewer served in Regional Centers
- Fewer mental health board commitments (from 741 in FY 04 to 273 in FY 07)
- Fewer emergency protective custody holds (from 2,601 in FY 04 to 2,336 in FY 07)

In addition, the six local Behavioral Health Regions received an additional $17.1 million for community-based services for FY 07–08. This funding will be used to enhance consumer involvement, provide crisis/emergency care, develop services for special populations, expand the number of providers of services, and continue to reduce the number of people served at a Regional Center.

Increased Community Services

Overall, there has been a 48% increase in admissions to community services from January 2004 – April 2008. The list below provides some specific examples.

Percent increase of admissions to community services
January 2004 – April 2008

- Dual Residential –286% Increase
- Assertive Community Treatment – 166% Increase
- Community Support - Mental Health – 59% Increase
- Community Support - Substance Abuse – 45% Increase
- Short Term Residential – 35% Increase
- Day Rehabilitation – 18% Increase
- Psychiatric Residential Rehabilitation –61% Increase

Source: Division of Behavioral Health / Final Report to the Behavioral Health Oversight Commission of the Legislature / June 20, 2008

Community Based Hospitals

Nebraska has made a strategic and focused effort to reduce these admissions and develop community based services. At one time, nearly all of the individuals who were under commitment by the Mental Health Boards received treatment services in one of the three Regional Centers in Lincoln, Hastings and Norfolk. One of the goals of Behavioral Health Reform was to change that pattern. Now the Nebraska Behavioral Health System (NBHS) has community based hospitals across the state with the capacity to receive Emergency Protective Custodies. These community based hospitals are Regional West (Scottsbluff), Great Plains (North Platte), Richard Young (Kearney), Mary Lanning (Hastings), Alegent Health (Omaha) and Douglas County Hospital Community Mental Health Center (Omaha). This capacity was expanded in 2008 with the following additions:

- It was reported on January 15, 2008 that Faith Regional Hospital in Norfolk NE officially opened 10 sub-acute beds by admitting one patient.
- Lasting Hope Recovery Center in Omaha NE officially opened April 8, 2008 with the first admission to the Special Care Unit.

Bed Allocation:

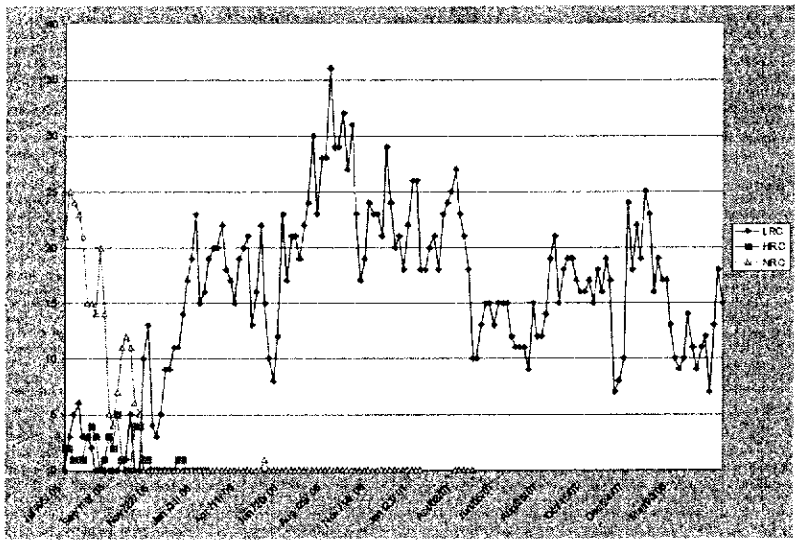
The Lincoln Regional Center Bed Allocation Plan allots a specific number of general psychiatric beds based on population to each of the six regions for utilization by consumers who are mental

health board committed to DHHS and who require longer term care than available in a community psychiatric hospital. The Regions are responsible for working with the community based crisis centers and hospitals to prioritize consumers for admission.

BEDS ALLOCATED TO EACH REGION
BASED ON 100 BED CAPACITY AT LRC REFORM PLAN

REGION	2005 Census	Dedicated Beds @ LRC	Allocated Beds @ LRC	TOTAL Beds @ LRC
1	4.98%	0	4	4
2	5.75%	0	5	5
3	12.78%	0	10	10
4	11.99%	0	10	10
5	24.25%	18	20	38
6	40.25%	0	33	33
Totals	100%	18	82	100

The reason this Bed Allocation plan has been successful is due to NBHS new community capacity. The demand for Regional Center admissions is down. The chart below shows the trend on referrals



from July 5, 2005 to March 3, 2008 to the Regional Centers. There are no referrals to Hastings nor Norfolk. All referrals are to Lincoln Regional Center only.

This is also reflected in the Mental Health Commitment Admissions to Behavioral Health Reform Units' in the Regional Centers over the last few year.

FY2002 = 871
FY2003 = 832
FY2004 = 741
FY2005 = 626
FY2006 = 490
FY2007 = 273

Scot Adams Comments to State Advisory Committee on Mental Health Services on 2/05/08

Scot L. Adams, Ph.D., Director, Division of Behavioral Health commented to the State Advisory Committee on Mental Health Services on 2/05/08.

- Between 2004 and 2007, Nebraska closed 232 adult and 16 adolescent mental health beds at the Regional Centers.
- Codification of Behavioral Health as term of choice – for example, under the Nebraska Behavioral Health Services Act, the term "Behavioral Health Disorder" is defined to mean, "mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder" [Section 71-804 (1)].
- Behavioral health reform created additional funds for community behavioral health services. The Division established priorities and guidelines and will give final approval to Region plans for using increased funding.

Summary of Scot Adams Comments to the Behavioral Health Oversight Commission of the Legislature Final Meeting on June 20, 2008.

- In FY1955, the census at the three Regional Centers reached an all-time high of 4,746.
- 1995: The Division initiated a major redesign effort focused on providing behavioral health services when/where needed, building up community alternatives, and reducing reliance on Regional Centers.
- LB 1354 (1998): A Task Force examined the delivery and financing of services for adults with mental illnesses or addictions, and efforts to redesign Nebraska's behavioral health system.
- LB 692 (2001): $8 M annually in new funding for community-based behavioral health services.
- LB 724 (2003): A road map for reform that included better services and outcomes for consumers, state leadership, Regional Governance, community-based services, integrated funding, and Legislative Oversight.
- LB 1083 (2004)

- Summary of Services:

New or enhanced served created through LB 1083 include:

Mental Health	Substance Abuse	Dual Disorder / Both MH & SA
Assertive Community Treatment	Community Support-SA	Dual Disorder Residential
Community Support-MH	Halfway House SA	Support Employment
Emergency Community Support	Intermediate Res SA	
Crisis Assessment	Methadone Maintenance	
Crisis Stabilization	Outpatient-SA	
Day Rehab	Short Term Residential (Enhanced)	
Day Treatment	Short Term Residential	
Intensive Community Services-MH	Social Detox	
Outpatient-MH	Therapeutic Community SA	
Psych Res Rehab MH		
Transitional Res MH		
Urgent Med Management		
Urgent Outpatient		
Housing Related Assistance		

Highlights – Regional Centers include:

- Hastings' adult beds closed.
- NRC has a new mission.
- Low readmission rate.

180-day Readmission rates (URS Table 20a)

- Uniform Reporting System (URS): Federal community mental health block grant
- URS compiles information submitted from all states to examine services use and outcomes among people who are served by state mental health care system.
- As part of URS, states submit readmission rates based on specified definitions and analysis methods.
- Readmission within 180 Days to state psychiatric hospitals - Civil (Non-Forensic) Patients (using URS Table 20a)

180-day Readmission Rates FY2006 – FY2007

	Nebraska		US Totals		
Fiscal Year	Discharges	% Readmissions w/in 180 Days Discharges	Discharges	% Readmissions w/in 180 Days Discharges	States Reporting
FY2006	575	10.30%	161,907	19.70%	50
FY2007	480	7.90%	158,043	19.90%	48

- **Duplicated Count** - Episodes of readmission divided by total discharges within the specified time period.
- Data reported under the Federal MH Block Grant - FY 2006 & 2007 Uniform Reporting System (URS) Table 20a
- NE FY2006 (July 1, 2005 to June 30, 2006) Analysis conducted by Nebraska DHHS Behavioral Health Division
- NE FY2007: (July 1, 2006 to June 30, 2007) Analysis conducted by UNMC

Behavioral Health Oversight Commission of the Legislature

The Behavioral Health Oversight Commission of the Legislature met for the last time on June 20, 2008. This included issuing a final report. The report included the following as **ACCOMPLISHMENTS / PROGRESS MADE**

Upon the passage of the Act, the Department of Health and Human Services developed the "LB 1083 Behavioral Health Implementation Plan", dated July 1, 2004. The state's behavioral health regions also established local plans for developing community-based services with the participation of consumers, family members, professionals and local leaders and officials.

Since 2004, significant progress has been made in the implementation of LB1083 and the reformation of the behavioral health system intended by the Act. These include:

1. **30% increase in the number of individuals receiving behavioral health services in the community**. The number of persons served in the community grew by more than 9,000 from fiscal year 2004 to fiscal year 2007. This represents a 30 percent increase in the number of

individuals receiving behavioral health services in the community. By providing community-based services, individuals that might have accessed the emergency system and perhaps would have been admitted to a regional center can now receive services closer to family and friends where their recovery may be quicker and more effective, and at much less risk of losing home and job.

2. **47% increase in admissions to identified community services.** The array and the capacity of community-based services has expanded significantly as a direct result of LB1083. Seven services were targeted as a priority for expansion in order to move patients from regional centers to the community. The total number of admissions to these services - Dual Residential, Assertive Community Treatment, Community Support for mental health and substance abuse, Short Term Residential, Day Rehabilitation, and Psychiatric Residential Rehabilitation - increased by 47% from FY2004 to FY2008. In addition, services such as Mobile Crisis Response Teams, Emergency Community Support, and even inpatient services in the community were developed or expanded.

3. **10% decrease in persons placed involuntarily in Emergency Protective Custody.** From fiscal year 2004 through fiscal year 2007, the number of persons placed in involuntary emergency protective custody (EPC) has decreased from 2,601 to 2,336. This is a 10 percent decrease over the four year period, and a 20 percent decrease from just six years ago. EPCs pose the risk of significant trauma to the individual needing behavioral health care, and utilizes significant resources of law enforcement. A decrease in EPCs is a significant indicator of increased access to community services.

4. **63% reduction in the number of involuntarily committed persons admitted to regional centers.** From fiscal year 2004 to fiscal year 2007, the number of involuntarily committed individuals admitted to regional centers decreased from 741 to 273, or 63%. This is another major indicator of the very real and positive impact of expanding both the array and the capacity of community-based services has had for Nebraska citizens with behavioral health disorders.

5. **Closure of 251 adult behavioral health beds at Hastings and Norfolk Regional Centers** consistent with the intent and purposes of the Legislature as stated in the statute.

6. **7.9% readmission rate to state regional center in Nebraska compared to 19.9% nationally.** The readmission rate within 180 days of discharge from a Nebraska regional center was 2 ½ times lower than the national rate in FY2007 and half that of the State's readmission rate in FY2004, providing evidence of the effectiveness of community services after discharge.

7. **Creation of an Office of Consumer Affairs and appointment of administrator within the Office; consumer *positions created* within each behavioral health region.** The Office of Consumer Affairs and administrator of this office were created by LB1083. The Office of Consumer Affairs incorporated two consumer liaisons who, for many years, had functioned within the Division to provide its consumer input internally. The administrator position was filled in January, 2006. The Division now contracts with each behavioral health region for a full time Behavioral Health Consumer Services Coordinator position.

8. **Peer support services are evolving across the State.** A number of providers have added peer positions. Consumers are advocating for peer driven, peer operated services with job descriptions and evaluation processes, many of which could be Medicaid approved for inpatient and community settings. These services are unique and emerging positions and disciplines in

individuals receiving behavioral health services in the community. By providing community-based services, individuals that might have accessed the emergency system and perhaps would have been admitted to a regional center can now receive services closer to family and friends where their recovery may be quicker and more effective, and at much less risk of losing home and job.

2. **47% increase in admissions to identified community services.** The array and the capacity of community-based services has expanded significantly as a direct result of LB1083. Seven services were targeted as a priority for expansion in order to move patients from regional centers to the community. The total number of admissions to these services - Dual Residential, Assertive Community Treatment, Community Support for mental health and substance abuse, Short Term Residential, Day Rehabilitation, and Psychiatric Residential Rehabilitation - increased by 47% from FY2004 to FY2008. In addition, services such as Mobile Crisis Response Teams, Emergency Community Support, and even inpatient services in the community were developed or expanded.

3. **10% decrease in persons placed involuntarily in Emergency Protective Custody.** From fiscal year 2004 through fiscal year 2007, the number of persons placed in involuntary emergency protective custody (EPC) has decreased from 2,601 to 2,336. This is a 10 percent decrease over the four year period, and a 20 percent decrease from just six years ago. EPCs pose the risk of significant trauma to the individual needing behavioral health care, and utilizes significant resources of law enforcement. A decrease in EPCs is a significant indicator of increased access to community services.

4. **63% reduction in the number of involuntarily committed persons admitted to regional centers.** From fiscal year 2004 to fiscal year 2007, the number of involuntarily committed individuals admitted to regional centers decreased from 741 to 273, or 63%. This is another major indicator of the very real and positive impact of expanding both the array and the capacity of community-based services has had for Nebraska citizens with behavioral health disorders.

5. **Closure of 251 adult behavioral health beds at Hastings and Norfolk Regional Centers** consistent with the intent and purposes of the Legislature as stated in the statute.

6. **7.9% readmission rate to state regional center in Nebraska compared to 19.9% nationally.** The readmission rate within 180 days of discharge from a Nebraska regional center was 2 ½ times lower than the national rate in FY2007 and half that of the State's readmission rate in FY2004, providing evidence of the effectiveness of community services after discharge.

7. **Creation of an Office of Consumer Affairs and appointment of administrator within the Office; consumer *positions created* within each behavioral health region.** The Office of Consumer Affairs and administrator of this office were created by LB1083. The Office of Consumer Affairs incorporated two consumer liaisons who, for many years, had functioned within the Division to provide its consumer input internally. The administrator position was filled in January, 2006. The Division now contracts with each behavioral health region for a full time Behavioral Health Consumer Services Coordinator position.

8. **Peer support services are evolving across the State.** A number of providers have added peer positions. Consumers are advocating for peer driven, peer operated services with job descriptions and evaluation processes, many of which could be Medicaid approved for inpatient and community settings. These services are unique and emerging positions and disciplines in

keeping with best practices and the intent of the New Freedom Commission. Consumers with provider support developed a peer support curriculum now offered for college credit by the University of Nebraska at Omaha This is consistent with the mandates of LB1083, and Nebraska's evolution into consumer driven best practices.

9. **Approximately $26 million in ongoing operational funding has been moved from regional centers to the community.** These additional funds calculated to less than $3,000 per person based on the 9,000 additional persons served in the community, compared to the $125,000 or more per bed at the State regional center. The dollars moved funded the expanded community service continuum and the expanded capacity within that continuum.

10. **Mental health agencies receiving 'reform' dollars have earned and maintained national accreditation,** evidence of an ongoing commitment to quality, consumer focused, and results oriented services. This is a baseline standard of quality to which all community-based mental health services are held as a condition of eligibility for funding, and one which is also adhered to by many of the community substance abuse services.

11. **$24.6 million dollars in private sector dollars raised as part of a public-private partnership formed in support of the goals of LB1083,** resulting in a new 64 bed crisis, acute, and sub acute resource in Omaha. This new physical resource is intended to significantly reduce the demand for Regional Center care for persons from Region 6 and, ultimately, help in the education and training of behavioral health professionals statewide. Such strong private sector support in behavioral health is virtually unprecedented, and brought widespread attention to our state and community.

12. **684 persons with serious mental illness receiving state housing assistance program through fiscal year 2007,** in recognition of the importance of safe, supportive, and affordable housing to the individual recovery process. This too, has drawn positive attention and praise from other parts of the country.

State Expenditures for Mental Health Services

The following shows the same trend on increased spending for Community Mental Health Services. The table shows the Maintenance of Effort (MOE) reported State expenditures for community mental health services from State Fiscal Year (SFY) 03-04 (from July 1, 2003 to June 30, 2004) to SFY 07-08.

State Fiscal Year (SFY)	State Expenditures For Mental Health Services		Increase Amount From Previous Year	Percentage Increase
SFY 03-04	$33,194,704.89	Actual		
SFY 04-05	$34,771,686.44	Actual	$1,576,981.55	4.8%
SFY 05-06	$42,214,436.44	Actual	$7,442,750.00	21.4%
SFY 06-07	$48,888,467.26	Actual	$6,674,030.82	15.8%
SFY 07-08	$64,518,620.66	Estimated *	$15,630,153.40	32.0%

* Estimated as of June 25, 2008.
source: Dan Ransdell – DHHS Operations / Financial Services - Budget Administration (06/25/2008)

In this case, the data show the State of Nebraska reporting for the Maintenance of Effort (MOE) requirements under the Federal Community Mental Health Services Block Grant. States are required to submit sufficient information for the Secretary (United States Department of Health and Human Services) to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

The State Expenditures for Mental Health Services increased from FY2004 to FY2008 by $31,323,915.77 (94.4%). The SFY 07-08 estimated State Expenditures for Mental Health Services (as of June 25, 2008) is $64,518,621. The increase is due to all of the Behavioral Health Reform efforts reported above including the closing of the Regional Centers.

Regional Center Discharge Follow-Up Services Project

Under Behavioral Health Reform, many changes have been made to the three Regional Centers. Regional Center Discharge Follow-Up Services Project was designed to help see what happened to consumers discharged from the Regional Centers starting January 2005.

The Division of Behavioral Health contracts with Shinobu Watanabe-Galloway, Ph.D. within the Epidemiology Department of the College of Public Health within the University of Nebraska Medical Center (UNMC) Omaha, NE to complete data analysis and reporting. UNMC completes many of the Uniform Reporting System tables needed under the Implementation Report for the Federal Community Mental Health Services Block Grant.

One of the primary duties under this UNMC contract is the Regional Center Discharge Follow-Up Services Project. The following tables come from the Year 3: Quarter 3 Report received by the Division of Behavioral Health on July 11, 2008.

The Year 3 Quarter 3 Report covers the cumulative data from the beginning of the project (January 1, 2005) to the end of this reporting period (March 31, 2008). Over this 39 month time period, a total of 1,112 people entered one of the Behavioral Health Reform units in one of the three Regional Centers and then were discharged.

The follow-up work is completed using data provided by the Department.

Table 1. DHHS Data Sources Used To Develop The Follow-Up Database

Data Sources	Description
Magellan	Magellan Behavioral Health Information System data. Covers community mental health and substance abuse programs.
MMIS	Medicaid Management Information Systems data. Provides Medicaid claims information.
N-FOCUS	Nebraska Family On-Line Client User System. Management information system operated by the Nebraska Health and Human Services System that supports over 40 programs.
AIMS/ Avatar	"Advanced Institutional Management Systems" (AIMS) and Avatar contain state psychiatric hospital data. As of January 2006, LRC began using Avatar exclusively, and Hastings and Norfolk Regional Centers were both fully converted to using Avatar exclusively by June 2007.

The DHHS transfers updated data sets twice a month to UNMC by a batch process developed by DHHS Information Technology personnel.

A Memorandum Of Understanding (MOU) between the Nebraska Department of Health And Human Services - Division of Behavioral Health and the Department of Correctional Services (Corrections) was entered into on July 19, 2007. The MOU covered all of the details needed to transfer data from Corrections to UNMC to complete data analysis under the Regional Center Discharge Follow-up Services contract and report the findings to the Division of Behavioral Health. In August 2007, Corrections provided the first transfer of data to UNMC. The Corrections data were linked to the DHHS data of those consumers in the Regional Center Discharge Follow-up study.

NDCS	Nebraska Department of Correctional Services (NDCS). Covers criminal history recorded for individuals arrested in Nebraska between January 1, 2005 and July 31, 2007 and sentenced to a state prison.

The following table shows the Regional Center units considered to be part of Behavioral Health Reform for the purposes of the Regional Center Discharge Follow-Up Services Project. Over the study time period, the units within the Regional Centers were changed as the Behavioral Health Reform progressed. Thus, the table below provides an example of the changes in the Regional Center Behavioral Health Reform units.

Table 2. Changes in Regional Center Units throughout the course of the follow-up study (page 4)

Regional Center	Regional Center Units: 1/1/05-8/31/06	Regional Center Units: 9/1/06-4/30/07	Regional Center Units: 5/1/07-4/1/08
Hastings	Residential Rehab (37)	Residential Rehab (37)	closed
Lincoln	Lincoln Short Term Care (STC)	Adult Psychiatric Acute Care (BLD3)	Adult Psychiatric Acute Care (BLD3)
	Community Transition Program (CTP)	Adult Psychiatric Extended Care (BLD 10 & 14)	Adult Psychiatric Extended Care (BLD 10 & 14)
Norfolk	Norfolk Geriatric Medical (1W)	Adult Behavioral Health Services Long Term (1W)	Adult Behavioral Health Services Long Term (1W)
	Transition/Rehabilitation (2W)	Adult Behavioral Health Services Short Term (2W)	Adult Behavioral Health Services Long Term (2W)
	Admissions (3W)	new mission	
	SPMI, Mixed (3E)	new mission	
	SPMI, Male (2E)	new mission	

The following table shows the Region of Admission and the Regional Center of discharge from January 2005 to the end of this reporting period March 2008.

Table 13. Region of admission[1] and regional center of discharge[2] among consumers in follow-up system[3]

	Discharge Regional Center			
Region of Admission	Hastings No. (%)	Lincoln No. (%)	Norfolk No. (%)	Total No. (%)
1	1	8	3	12 (1.1)
2	16	18	14	48 (4.3)
3	159	19	25	203 (18.3)
4	13	38	100	151 (13.6)
5	17	280	10	307 (27.6)
6	26	151	202	379 (34.1)
Other[4]	2	1	9	12 (1.1)
Total	**234 (21.0)**	**515 (46.3)**	**363 (32.6)**	**1,112 (100.0)**

Table 13 Source: AIMS/Avatar, Magellan

1. Based on county of residence at earliest known AIMS/Avatar admission, or Magellan admission, if county was missing in AIMS/Avatar.
2. Based on the first discharge data if more than one.
3. Unduplicated counts of consumers entering the follow-up system between 01/01/05 – 03/31/08.
4. "Other" includes the descriptions "Not Applicable" and "Unknown" found as labels in the county of admission field.

The following table provides an overall look at the use of services once the consumer was discharged from a Regional Center into a community setting.

Table 18. Use of mental health[1] and non-mental health[2] services in the community among consumers in follow-up system[3] (page 26)

Description	No.	Percentage
Used mental health and non-mental health services	939	84.4
Used mental health service only	91	8.2
Used non-mental health service only	17	1.5
Used no service	8	0.7
Out-of state (no data available)	57	5.1
Total	1112	100.0

Sources: AIMS/Avatar, Magellan, MMIS, N-FOCUS

1. Refers to mental health services consumers received in the community setting following the discharge from a regional center. These counts include out-patient regional center services.
2. Refers to all non-mental health services consumers received in the community setting following the discharge from a regional center. These include treatment for physical illness and social services.
3. Unduplicated counts of consumers entering the follow-up system between 01/01/05 – 03/31/08.

One of the important findings from the Regional Center Discharge Follow-Up Services Project is noted below. Serious Mental Illness (SMI), Substance-Related Disorder (SRD) and Personality Disorder (PD) are the most frequent psychiatric diagnosis combinations among consumers in follow-up system. The combination of SMI/SRD/PD is the most frequent combination of diagnosis overall, for those reporting no readmission (361 / 40.3% of 896), for one readmission (81 / 49.7% of 163), for those with two or more readmissions (36 / 67.9% of 53).

NOTE: 38 (63%) of the 60 of individuals found in the Nebraska Department of Correction System (NDCS) who were also in the follow-up data base had Serious mental illness, Substance-related disorder, and Personality disorder.

Table 39. Most frequent psychiatric diagnosis combinations[1] among consumers in follow-up system[2] by number of readmission

Diagnosis	Number of readmissions			
	0 (no readmission) No. (%)	1 (readmitted once) No. (%)	≥2 (readmitted twice or more) No. (%)	Total No. (%)
Serious mental illness[3] Substance-related disorder Personality disorder	361 (75.5)	81 (16.9)	36 (7.5)	478 (100%)
Serious mental illness Substance-related disorder	158 (87.8)	20 (11.1)	2 (1.1)	180 (100%)
Serious mental illness Personality disorder	124 (77.0)	27 (16.8)	10 (6.2)	161 (100%)
Serious mental illness	133 (91.1)	13 (8.9)	0 (0.0)	146 (100%)
Substance-related disorder Personality disorder	31 (86.1)	5 (13.9)	0 (0.0)	36 (100%)
Other diagnostic combinations	89 (80.2)	17 (15.3)	5 (4.5)	111 (100%)
totals	896 (80%)	163 (15%)	53 (5%)	1,112 (100%)

Sources: AIMS/Avatar, Magellan, MMIS, N-FOCUS
1. Based on all diagnostic codes found in the Axis data.
2. Unduplicated counts of consumers entering the follow-up system between 01/01/05 – 03/31/08.
3. Serious Mental Illness (SMI) includes both high and low functioning SMI.

Table 3. Psychiatric diagnostic codes used to identify major mental illness groups (page 7)

Serious Mental Illness (low function)	Axis I = 295.00 – 298.90 and Axis V (GAF) below 60
Serious Mental Illness (high function)	Axis I = 295.00 – 298.90 and Axis V (GAF) 60 and higher
Substance Related Disorder	Axis I = 291.00-291.99; 292.00-292.99; 303.00-303.99; 304.00-304.99; 305.00-305.99
Personality Disorder	Axis II = 301.00 – 301.99 (excluding 301.13)
Mental Retardation	Axis II = 317.00, 318.00, 318.10, 318.20
Autistic Disorder	Axis I = 299.00
Dementia	Axis I = 290.40-290.43; 294.10-294.11
Other	All other diagnosis not included above

Nebraska Justice-Mental Health System Collaboration Planning Project

The Division of Behavioral Health has received grant awards from the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance (BJA) Grant titled "Justice and Mental Health Collaboration Program" (CDFA #16.745).

- The Division implemented a CATEGORY I: PLANNING grant ($50,000) for the time period from 11/01/2007 to 10/31/2008. The overall goal for this grant was to improve the cross-disciplinary system of care for persons with mental illness who encounter the criminal justice system in Nebraska by strengthening early intervention efforts to mitigate recidivism and

prevent persons, especially juveniles, from cycling through institutionalized settings throughout their lives. The final product of this grant will be a Justice Behavioral Health Statewide Strategic Plan.

- The Division received notice that the CATEGORY II: PLANNING AND IMPLEMENTATION grant was awarded. This grant covers the time period of 11/01/2008 to 10/31/2011 with a grant maximum of $250,000 ($100,000 year one; $100,000 year two; $50,000 year three). The overall goal here is to develop collaborative partnerships to address interagency coordination & communication in order to implement system improvements for persons with mental illness in the Criminal Justice System. The target population is young adults 18 to 24 years of age.

The Division of Behavioral Health sponsored a strategic planning workshop on December 5&6, 2007 in Lincoln. A strategic planning report resulted from that planning session. The report can be found at the following address:
http://www.hhs.state.ne.us/beh/NE_CriminalJusticeMHReport&Attachmts-Jan28_2008.pdf

The report outlined the information presented during the two day session, summarizes the strategic planning outputs, and provides 14 recommendations for moving Nebraska forward in addressing the needs of justice involved individuals with mental illness. A Steering Committee was developed from the participating state agencies for this planning project. This group prioritized specific areas which could be addressed in Nebraska as well as have the greatest benefit and impact. These five areas were identified as the goals for the CATEGORY II: PLANNING AND IMPLEMENTATION grant. They were also the focus for the input and comment received on October 10, 2008.

The five areas identified were:

Priority Area 1: Provide statewide Crisis Intervention Team (CIT) training for Law Enforcement officers and make clear linkages with local crisis response teams.

Priority Area 2: Expand or improve access to crisis stabilization services with improved coordination with law enforcement officers.

Priority Area 3: Implement standardized mental health and substance abuse screening instruments in the jails that prompt referrals for services.

Priority Area 4: Increase resources to community mental health to provide diversion services through the use of Forensic Intensive Case Management.

Priority Area 5: Enhance affordable supportive housing for justice involved youth transitioning to adulthood.

NEW

On October 10, 2008, the Division of Behavioral Health sponsored the Nebraska Justice Behavioral Health Statewide Strategic Planning Meeting in Lincoln, NE. The purpose of the meeting was to provide input on Nebraska's Draft Strategic Plan designed to build collaborative partnerships through interagency coordination and communication to implement system improvements for persons with behavioral health disorders in the Nebraska's criminal justice system. A total of 65 people attended the meeting.

NOTE: In the 2007 session, Legislative Bill 669 (Adopt the Nebraska Behavioral Health Jail Diversion Planning and Coordination Advisory Council Act), was introduced by Senators Hudkins, Avery, and Pedersen. As a result, Legislative Resolution 99 (LR99) was approved as an interim study to examine policies relating to the incarceration of persons with mental illness in Nebraska's correctional facilities, including juvenile facilities. In the 2008 session, LB 669 and LR 99 died in the Judiciary Committee.

Adult – Child: Purpose State FY BG Expended - Recipients - Activities Description (Oct.16, 2008)
Narrative Question:

A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

Use of Federal Mental Health Block Grant in FY2008

This is a report on the purposes for which the Federal Community Mental Health Services Block Grant monies for State Fiscal Year 2008 were expended, the recipients of grant funds, and a description of activities funded by the grant.

The Recipients of Grant Funds

The six Regional Behavioral Health Authorities were the recipients of the funds. The "Nebraska Behavioral Health Services Act" (Neb. Rev. Stat. §§ 71-801 to 71-818) was passed by the Legislature and signed by the Governor 2004 with amendments in 2005 and 2006. The NBHS Act specifically authorizes "Regional Behavioral Health Authorities" (RBHA) under Neb. Rev. Stat. §§ 71-807 to 71-809. The NBHS Act revised the regional administration of the system. The NBHS Act retained the six geographic "regions" established in 1974. It re-authorized the six regions and renamed them "Regional Behavioral Health Authorities" (RBHA). The RBHA are local units of government organized under the Interlocal Cooperation Act for the purpose of planning, organizing, staffing, directing, coordinating and reporting of the local service systems of mental health, and substance abuse within assigned geographic areas (regions). Each county participating in the region appoints one county commissioner to the Regional Governing Board to represent that county and to participate in the decision making of the Regional Behavioral Health Authority (RBHA). The RBHA is staffed by the Regional Program administrator who in turn hires sufficient staff to accomplish the tasks within the region. RBHA contracts with local providers for service delivery.

NOTE: This report is prepared from the point of view of the direct contractors, that is, the six Regional Behavioral Health Authorities under contract with the DHHS Division of Behavioral Health. In viewing this report, one needs to keep in mind that:

- The Federal Community Mental Health Services Block Grant funds must be obligated and expended within the two-year period.
- There is a lag time for the cash to flow from a Federal Notice of Grant Award, into a contract with Regional Behavioral Health Authorities and ending in a form of payment for services.
- On a technical accounting basis, the regions' reports of actuals for a Fiscal Year represent about the first 40 percent of the previous Block Grant award ("old") and the remaining 60 percent from the more recent award ("New"). Thus, in any given year, the contracts between the DHHS Division of Behavioral Health and the Regional Behavioral Health Authorities use Community Mental Health Services Block Grant funds from two grant years.

The Federal Fiscal Year 2008 Award

According to the Notice of Award issued on 07/10/2008 for the program "Block Grants for Community Mental Health Services", the total FY2008 Federal funds approved for Nebraska was **$1,973,901** during Federal Fiscal Year 2008 (October 1, 2007 to September 30, 2008) with the award period starting 10/01/2007 and ending 09/30/2009.

Since FY2004, Nebraska has been cut. From FFY2004 to FFY2008, the Nebraska allocation has been cut $132,082 (6.27%).

		Cut from FY2004	
	Federal MH Block Award	funds cut from Previous Year	percent cut
FFY2004	$2,105,983		
FFY2005	$2,086,159	($19,824)	-0.90%
FFY2006	$2,050,210	($35,949)	-1.70%
FFY2007	$2,006,208	($44,002)	-2.10%
FFY2008	$1,973,901	($32,307)	-1.61%

Using the final allocation for FY2008, the Federal Community Mental Health Services Block Grant percentage total of funds for non-Medicaid mental health expenditures is small. State Fiscal Year 07-08 expenditures as reported on the MOE = $64,518,621. The FY2008 Final Nebraska allocation under the Federal Community Mental Health Services Block Grant = $1,973,901 (3% of the State funds as reported under the MOE.).

The following chart shows the Nebraska State Expenditures for Community Mental Health Services as reported on the Maintenance of Effort (MOE) and the actual Federal Community Mental Health Services Block Grant Award from FY1998 to FY2008.

	State MOE+	Federal MH Block Award
FY1998	$16,505,943	$1,300,783
FY1999	$19,436,770	$1,367,377
FY 2000	$18,096,705	$1,727,251
FY 2001	$20,483,341	$2,011,272
FY 2002	$24,015,746	$2,042,087
FY 2003	$29,036,852	$2,099,881
FY 2004	$31,207,611	$2,105,983
FY 2005	$36,970,889	$2,086,159
FY 2006	$45,342,329	$2,050,210
FY 2007	$48,888,467	$2,006,208
FY2008	$64,518,621	$1,973,901
Fund increase FY1998 to 2008	**$48,012,678**	**$673,118**
percent increase (1998 to 2008)	**291%**	**52%**

Over the time period from FY1998 to FY2008, the State funds expended for Community Mental Health have increased by $48,012,678 (291%). During that same time period, the Federal Community Mental Health Services Block Grant has increased by $673,118 (52%).

The final notice regarding the Nebraska allocation under the Community Mental Health Services Block Grant from the Center for Mental Health Services (CMHS) was received April 2, 2008.

Nebraska was required to report the modifications to the Community Mental Health Services Block Grant application due to the FY2008 cut of $32,306 (-1.6%). Nebraska modified its Community Mental Health Services Block Grant application in order to implement the cuts. The modification to the Nebraska application is based on the following:

- The notification for the Federal Fiscal Year (FFY) 2007 was received on May 4, 2007 with a revised award of $2,006,208 which was reduced by $44,002 (2.1%).
- In the final MH Block Grant for FFY2008 Nebraska's allocation is $1,973,901, an additional reduction of $32,307 (1.6%).

Nebraska implement these funding reductions several ways. There was $17,992 reduction last year from the FFY2007 by eliminating the Rural Equity Fund. The balance of $26,010 needed to be passed on to the Regional Behavioral Health Authorities. As noted in the Community Mental Health Services Block Grant FY2007 implementation report, the decision was made to defer that reduction one State Fiscal Year (SFY) due to the following reasons:

- The Federal Community Mental Health Services Block Grant funds must be obligated and expended within the two-year period,
- There is a lag time for the cash to flow from a Federal Notice of Grant Award, into a contract with Regional Behavioral Health Authorities and ending in a form of payment for services,
- The contracts between the Division of Behavioral Health and the six Regional Behavioral Health Authorities follow the State Fiscal Year (SFY) from July 1 to June 30 each year,
- In any given year, the contracts between the Division of Behavioral Health and the Regional Behavioral Health Authorities use Community Mental Health Services Block Grant funds from two grant years. The first 40 percent in the SFY uses funds from the previous FFY Block Grant award and the remaining 60 percent are from the more recent award.

As a result, Nebraska implemented the second phase of the FFY2007 cut and the full FFY2008 cut in one reduction with the six Regions. Between the cuts in FFY2007 and FFY2008, a total of $58,317 (3.0%) [remaining FFY2007 cut of $26,010 plus the full cut of $32,307 from FFY2008 equals $58,317 total cut in SFY 2009] was reduced from the SFY 2009 (from July 1, 2008 to June 30, 2009) contracts with the six Regional Behavioral Health Authorities.

The following table shows the actual allocation of Federal Community Mental Health Block Grant funds in SFY2008 and SFY2009 as well as the percent of total each Regional Behavioral Health Authority received in those State Fiscal Years. That percent of total is then compared to the 2007 Nebraska population estimates by the U.S. Census Bureau.

	Allocation of the Federal MH Block Grant				Census Population Estimates For NE as of July 1, 2007	
Region	SFY 2008	SFY 2009*	% of Total	Change from FY2008	Number	% of Total
1	$186,251	$180,619	9.66%	($5,632)	86,072	4.85%
2	$187,795	$182,116	9.74%	($5,679)	99,683	5.62%
3	$268,202	$260,092	13.91%	($8,110)	222,813	12.56%
4	$272,545	$264,303	14.13%	($8,242)	205,912	11.60%
5	$438,759	$425,491	22.75%	($13,268)	434,379	24.48%
6	$574,971	$557,584	29.81%	($17,387)	725,712	40.90%
Totals	$1,928,523	$1,870,205	100%	($58,318)	1,774,571	100.00%

In Nebraska, of the 93 counties, there are six designated as "Metropolitan Statistical Areas" by the U.S. Census Bureau. These counties are

- Region 4 – Dakota county (includes South Sioux City) connected to Sioux City, Iowa.
- Region 5 – Lancaster county (includes City of Lincoln).
- Region 6 – Douglas (includes City of Omaha), Sarpy, Cass, Washington counties.

The overall pattern of allocation for the Federal Community Mental Health Services Block Grant favors the rural areas of Nebraska. This is consistent with the "President's New Freedom Commission on Mental Health" Goal 3 (Disparities in Mental Health Services Are Eliminated). Recommendation 3.2 (Improve access to quality care in rural and geographically remote areas). Thus, the use of the funds in this manner helps to improve access to quality care in rural and geographically remote areas.

The State Advisory Committee on Mental Health Services, Nebraska's Mental Health Planning Council, met on May 6, 2008 to review this modification. As a result, the Chair of the State Advisory Committee, Bev Ferguson, summarizes the Committee's concerns in her comments:

> As Chair of the Mental Health Advisory Council, I received and reviewed the changes to the Mental Health Block Grant. The changes were in response to the notification of a cut in the funding of that Grant to Nebraska by CMHS. I am concerned about the formula used to determine the funding allocation for each state. It appears to penalize states such Nebraska without considering the unique and costly factor of providing services for such rural settings. The dollar amount Nebraska receives is already substantially smaller than most states. Nebraska has so many rural areas with high need for mental health services, that even the smallest of cuts is felt. Receiving cuts year after year is very discouraging to the people of Nebraska that are trying to move forward in providing quality and available mental health services, in response to an immediate need of its consumers. I sincerely hope the trend to cut these funds to Nebraska will stop soon.

EXPENDED - the information below shows purpose for which the block grant monies for State FY 2008 were expended

The MH Block Grant funds are used in three ways:

(1) The primary purpose was to purchase community mental health services via contracts with the six Regional Behavioral Health Authorities. These funds need to be used consistent with the restrictions in Federal law and the annual guidance.

(2) The 5% administrative portion was used to support MH Block Grant Adult Goal #2: Empower Consumers. The application for the MH Block Grant provides details on this.

(3) Funds used to help support the "Independent Peer Review" (per Section 1943 in Attachment A - Community Mental Health Services Block Grant Funding Agreements).

Summary Federal Fiscal Year 2008	FY2008
(1) Allocation available to Regions in FY2009 Contracts (July 1, 2008 to June 30, 2009)	$1,870,206
(2) State administration 5% set aside from final allocation for Adult Goal: Empower Consumers	$98,695
(3) Independent Peer Review (Federal Requirement per Section 1943 in Attachment A - Community Mental Health Services Block Grant Funding Agreements).	$5,000
Total Federal Community Mental Health Services Block Grant / Fiscal Year 2008 Award (actual)	$1,973,901

FY2008 Actual Expenditures / Federal Community Mental Health Services Block Grant

Federal Community Mental Health Services Block Grant Funds
Expended in State Fiscal Year 2008 - as reported by the Regional Behavioral Health Authorities

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Totals
Adult Services							
Day Treatment – MH					$37,411		$37,411
Outpatient Therapy - MH	$26,569	$54,530	$38,006	$34,798	$144,132	$168,840	$466,875
Outpatient Therapy – Dual			$10,325				$10,325
Medication Management – MH	$5,039	$34,750	$50,975				$90,764
Day Support/Peer Support - MH	$33,360		$41,600				$74,960
Supported Employment – BH	$1,440		$15,534	$20,065			$37,039
Day Rehabilitation			$811			$22,176	$22,987
Psych Residential Rehab						$183,955	$183,955
Community Support – MH		$73,457	$14,429	$32,086			$119,972
Flex Funds - MH			$22				$22
Capacity Access Guarantee			$721	$1,706			$2,427
Adult Totals	$66,408	$162,737	$172,423	$88,655	$181,543	$374,971	$1,046,737
Children/Youth Services							
Professional Partner			$50,000	$80,000	$154,740	$200,000	$484,740
Professional Partner - School WRAP	$78,000			$83,850			$161,850
C/Y Day Treatment (P.L. 102-321)			$32,500				$32,500
C/Y Intensive Outpatient – MH					$18,808		$18,808
C/Y MH Therapeutic Consult (P.L. 100-690)	$40,850	$16,309	$10,356		$68,800		$136,315
Youth Totals	$118,850	$16,309	$92,856	$163,850	$242,348	$200,000	$834,213
% of Total Federal on Youth Services							
GRAND TOTAL Fed MH Block $ Report of Actual by Region	$185,258	$179,046	$265,279	$252,505	$423,891	$574,971	$1,880,950

Source: Nebraska Division of Behavioral Health; as reported by the six Regional Behavioral Health Authorities / October 2008

Based on the Report of Actuals for State Fiscal Year 2008 from the six Regional Behavioral Health Authorities, the total expenditures for Adult services was $1,046,737 (55.6%) and for Youth services $834,213 (44.4%). The Federal Mental Health Block Grant Top Expenditures by Program for Adult services were Outpatient Therapy – MH, Psych Residential Rehab, Community Support – MH, Medication Management – MH, and Day Support/Peer Support – MH. The Top Expenditures for Youth services were Professional Partner, Professional Partner - School WRAP, and C/Y MH Therapeutic Consult (P.L. 100-690). Below is a chart showing the top funded programs.

Federal Mental Health Block Grant Top Expenditures by Program

Total Funds Expended in State FY2008	$1,880,950	100.00%
Adult Services		
Outpatient Therapy - MH (Ind/Grp/Fam)	$466,875	24.8%
Psych Residential Rehab	$183,955	9.8%
Community Support – MH	$119,972	6.4%
Medication Management – MH	$90,764	4.8%
Day Support/Peer Support – MH	$74,960	4.0%
Total Adult Services	$936,526	49.8%
Children/Youth Services		
Professional Partner	$484,740	25.8%
Professional Partner - School WRAP	$161,850	8.6%
C/Y MH Therapeutic Consult (P.L. 100-690)	$136,315	7.2%
total Children/Youth Services	$782,905	41.6%
State Total - top funded programs	$1,719,431	91.4%

DESCRIPTION OF ACTIVITIES / ADULT SERVICES

- Day Treatment – Specialized medically based day program for persons with serious mental illness that enables a person to live independently and still attends an intensive program including assessment, individual, family and group therapy, and medication services as developed by a multidisciplinary team. Programming usually involves 6-8 hours of activity per day/6-7 days per week. Length of service varies depending on individual needs but is usually not longer than 21-45 days.
- Outpatient/Assessment – Assessment, diagnosis and psychotherapy/counseling for a variety of mental health problems which disrupt individual's life that includes counseling and talk therapy treatment to change behavior, modify thought patterns, cope with problems, improve functioning; may include coordination to other services to achieve successful outcomes. Length of service varies depends on individual illness and response to treatment but averages 10 sessions at least once per week. Group therapy sessions include approximately 3-8 persons. Family counseling are included in this service level. Dual means simultaneous integrated treatment for individuals with serious mental illness and chemical dependence.
- Medication Management – Prescription of appropriate psychotropic medication (usually, but not limited to persons with severe and persistent mental illness), and follow-up to therapeutic response, including identification of side effects. Medication checks usually take 15-30 minutes with the psychiatrist, an/or a nurse or case manager.
- Day Support (Drop-In Center w/Peer Support) -- Facility based program for persons with severe and persistent mental illness. This transition "drop-in" center for persons who have not yet enrolled in Day Rehabilitation, or who have completed their rehab plan in the Day Rehab service and want to continue to socialize with friends they have made at the Day Rehab service is designed to engage consumers. This service does not require a service plan but provides an environment to be with other people who share the same life and illness situation. Persons with severe and persistent mental illness are hired as peer specialist staff in this program. Additional support including outreach are the main focus of this drop in center. Pre-Day Rehab consumer length of stay may be

3-6 months. Post-Day Rehab consumer length of service is very individualized and may range from 6 months – 5+ years.

- Supported Employment (SE) – Evidenced-based service designed to promote rehabilitation and return to productive employment for persons with behavioral health disorders age 19 and older. Behavioral health disorders are mental illness or alcoholism, drug abuse, or related addictive disorder. Problem gambling is specifically excluded. The service employs a team approach for treatment with the employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e. not sheltered workshops, not onsite at SE or other treatment agency offices, employment in enclaves or pre-vocational training), competitive (i.e., jobs are not exclusively reserved for SE consumers, but open to public), in normalized settings and utilize multiple employers. The team is assertive in engaging and retaining consumers in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others as appropriate. SE services are coordinated with Vocational Rehabilitation.
- Day Rehabilitation – Facility based day program for a person with severe and persistent mental illness that focuses on psychosocial rehabilitation after treatment has stabilized the mental illness. Provides prevocational and transitional employment services, planned socialization, skill training in activities of daily living, medication management, and recreation activities are focused on returning a person to work and maintaining independence in the community. Programming usually involves 5 hours of activity per day/5 days per week and some weekends. Length of service varies depending on individual needs but is usually not longer than 6 months – 5 years.
- Residential Rehabilitation (Psych Res Rehab) – 24 hour, residential facility in the community for persons with severe and persistent mental illness. Persons in this service need the 24-hour structured psychosocial rehabilitation and medication management to regain or relearn skills that will allow them to live independently in their communities. Length of service varies depending on individual needs but is not longer than 4-8 months. Length of service varies depending on individual needs but is usually not longer than 9-18 months.
- Community Support – With 24 hour, 7-day/week availability, provides consumer advocacy, ensures continuity of care, active support in time of crisis, provides direct skill training in the residence and community, provide or arrange for transportation, arrange for housing, acquisition of resources and assistance in community integration for individuals with severe and persistent mental illness. Length of service varies depending on individual needs but is usually not longer than 6 months – 2 years.

DESCRIPTION OF ACTIVITIES / CHILDREN/YOUTH SERVICES

- Professional Partner – Strength-based, family centered approach to working with children with serious emotional disturbances and their families. Access to services on a 24-hour, 7day/week basis. Uses a wraparound approach to coordinate services and supports to families. Includes coordinated assessment, flexible funding to provide support, based on needs as outlined by a multidisciplinary team. Emphasizes family empowerment and involvement in planning.
- School Wraparound – In this variation of the Professional Partner Program, a special education teacher, team teacher, or school social worker works with the Professional Partner and the Child and Family Team to coordinate the school plan. Based on the LaGrange Area Department of Special Education (LADSE) approach in LaGrange, Illinois, a team of two wraparound service coordinators are based in the school. Planning efforts around the child and family create an environment in which the school is an integral part of the overall assessment and support for the child and his/her family. This School-Based Wraparound Approach allows the teacher and/or other school personnel to feel comfortable voicing classroom based concerns (academic and behavioral) and members of the Child and Family Team are also able to understand these concerns. The two individuals work closely together as a team to assist and coordinate services to a combined caseload

of approximately 20 children/families. Both individuals bring specific strengths to the team from their varied backgrounds in the school and in the community.

- Day Treatment (P.L. 102-321) – Facility based program serving children and adolescents with Severe Emotional Disturbance. Intensive, non-residential service providing counseling and family services, education, behavior modification and skill building, promoting reintegration back to the child's regular school.
- Outpatient/Assessment – Assessment, diagnosis and psychotherapy/counseling for mental health problems which disrupt a youth's home, school, family functioning; treatment focuses on changing behavior, modifying thought patterns, coping with problems, improving functioning and may include coordination to other services to achieve successful outcomes. Length of service varies depending on individual needs but is usually not longer than 10 sessions no more than once per week.
- Therapeutic Consultation (P.L. 100-690) – Collaborative, clinical intervention for youth with early indications of Severe Emotional Disturbance. Multidisciplinary based interventions with family, teachers and mental health professional involvement in the school or other natural setting.

Child - Most Significant Events that Impacted the State in the Previous FY
Narrative Question:
Child - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

Recent Significant Achievements

A great deal of the DHHS accomplishments made represent the success of the State Infrastructure Grant (SIG) which has been implemented for the last four years and is entering into its fifth and final year. The recommendations made by the Steering Committee for SIG have increased the DHHS development of organizational and financial structures, policy changes, needs assessment and strategic planning for better service delivery for children/youth with severe emotional disturbances. Several pilot projects have been developed and few more heading into fruition as we bridge our last fiscal cycle. A sampling of these projects include the expansion of a single assessment tool-the Comprehensive Family Assessment, Crisis Response trainings, Program Evaluations, Evidence based Practice, and the inclusion of family voice via the strengthening of the family organizations in the local communities.

The Early Childhood and Youth Subcommittee investigated evidence based practices for special populations and increase youth involvement in all levels of planning. The Nebraska Federation of Families has begun Project YES, which is a youth led program for young people addressing severe emotional disturbances. In addition, a curriculum was developed to promote provider screening for social emotional and behavioral development of children ages birth to five. This curriculum was created in collaboration with DHHS, the University of NE Public Policy Center and the Nebraska Medical Association as an interactive web based tool and is approved for continuing education credit hours by the Nebraska Nurses Association. The Perinatal Depression screening toolkit that was developed in 2006 was launched in 2007 and materials are still being utilized by mental health and healthcare providers across the state. This curriculum may be viewed at www.dhhs.ne.gov/PerinatalDepression.

The DHHS Division of Behavioral Health and Division of Child and Family Services have participated in the Nebraska "Through the Eyes of the Child" project which initiates awareness of a child's journey through the juvenile justice system and increases visibility of a child or adolescent's special mental health needs. There has been considerable effort to link the Office of Consumer Affairs at the state and local level with the state and local family organizations to increase collaborative efforts to ensure family/youth and consumer voice in all levels of service planning. This effort will be a priority for the next year and will receive technical assistance through the SIG funding. In addition, three brochures were created and distributed throughout the state as a response to the complications families and youth endure while addressing their mental health needs. These three learning tools are: the "Children's Service Initiative", which describes how to access mental health and substance abuse services for Nebraska children; the "Your Child and Psychiatric Medications", which aids parents in addressing and inquiring about the potential meds a young person may be prescribed; the "Adolescents and Psychiatric Medications", which aids youth on their journey to learn and deal with their potentially prescribed meds. These tools have proven very beneficial and are distributed via paper and web.

The Together for Kids and Families statewide project has made great strides in their collaborative interagency efforts to address the identification and early detection/screening for meeting early childhood mental health needs. Eight work groups have been meeting since March of 2004 to develop and complete the implementation plan created for their initial grant from the Maternal and Child Health Bureau, Us Health and Human Services. In addition, the statewide implementation of Early Childhood Positive Behavioral Supports and interventions is progressing through dialogue

and thoughtful planning. The statewide leadership team includes members from early intervention, community programs, state government, parent groups, higher education, Head Start and schools. This team formed a vision of all young children in Nebraska having access to services that meet their social-emotional, behavioral needs and a mission to use the Early Childhood Positive Behavioral Interventions and Supports to build a system of support for families with children to promote healthy social, emotional and behavioral development. Between June 2007 and April 2008, 725 people have attended trainings on this program.

Nebraska FY 2008 Uniform Reporting System (URS)

Prepared to Meet the Requirements of the

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT
PART E: Uniform Data on Public Mental Health System

U.S. Department of Health & Human Services
Substance Abuse & Mental Health Services Administration (SAMHSA)
Center for Mental Health Services (CMHS)

By:

Nebraska Department of Health and Human Services
Division of Behavioral Health

DRAFT for review on November 4, 2008
By the Nebraska State Advisory Committee on Mental Health Services

NOTE:

The Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health has a contract with the Epidemiology Department in the College of Public Health at the University of Nebraska Medical Center (UNMC) to complete selected the Uniform Reporting System Tables (URS) needed for the Community Mental Health Services Block Grant implementation report for the time period from July 1, 2007 to June 30, 2008. UNMC uses data transferred from DHHS to complete this work. Due to technical problems in data transfer, these selected tables have not been completed.

This review copy shows the URS Tables ready for submission to CMHS.

Table 1. Profile of the State Population by Diagnosis

This table summarizes the estimates of adults residing within the State with serious mental illness (SMI) and children residing within the state with serious emotional disturbances (SED). The table calls for estimates for two time periods, one for the report year and one for three years into the future. CMHS will provide this data to States based on the standardized methodology developed and published in the Federal Register and the State level estimates for both adults with SMI and children with SED.

Table 1.		
Report Year:	2008	
State Identifier:	NE	
	Current Report Year	**Three Years Forward**
Adults with Serious Mental Illness (SMI)	71,096	
Children with Serious Emotional Disturbances (SED)	34,897	

Note: This Table will be completed for the States by CMHS.

source:
State Data Infrastructure Coordinating Center (NRI)
2006 SMI and SED Estimates for Table 1
http://www.nri-inc.org/projects/SDICC/urs_forms.cfm

34,897 = average of level of functioning score = 60
Number of Children with Serious Emotional Distrubances, age 9 to 17, for Nebraska, 2006

71,096 = Civilian Population with SMI (5.4%)
Number of Persons with Serious Mental Illness, age18 and older, for Nebraska, 2006

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 9: NOMS Social Connectedness & Functioning			
Report Year (Year Survey was Conducted):	2008		
State Identifier:	NE		
Adult Consumer Survey Results:	**Number of Positive Responses**	**Responses**	**Percent Positive (calculated)**
1. Social Connectedness	720	944	76%
2. Functioning	809	1,006	80%
Child/Adolescent Consumer Survey Results:	**Number of Positive Responses**	**Responses**	**Percent Positive (calculated)**
3. Social Connectedness	103	127	81%
4. Functioning	76	125	61%

Comments on Data:

Adult Social Connectedness and Functioning Measures

1. Did you use the recommended new Social Connectedness Questions? (●) Yes ( ) No _____ Measure used
2: Did you use the recommended new Functioning Domain Questions? (●) Yes ( ) No _____ Measure used

3. Did you collect these as part of your MHSIP Adult Consumer Survey? (●) Yes ( ) No

If No, what source did you use?

Child/Family Social Connectedness and Functioning Measures

4: Did you use the recommended new Social Connectedness Questions? (●) Yes ( ) No _____ Measure used
5: Did you use the recommended new Functioning Domain Questions? (●) Yes ( ) No _____ Measure used

6. Did you collect these as part of your YSS-F Survey? (●) Yes ( ) No

If No, what source did you use?

Please use the same rules for reporting Social connectedness and Functioning Domain scores as for calculating other Consumer Survey Domain scores for Table 11: E.g.:

1. Recode ratings of "not applicable" as missing values.
2. Exclude respondents with more than 1/3rd of the items **in that domain missing.**
3. Calculate the mean of the items for each respondent.
4. FOR ADULTS: calculate the percent of scores less than 2.5. (percent agree and strongly agree).
5. FOR YSS-F: calculate the percent of scores greater than 3.5. (percent agree and strongly agree).

Items to Score in the Functioning Domain:

Adult MHSIP Functioning Domain:

1 I do things that are more meaningful to me.
2 I am better able to take care of my needs.
3 I am better able to handle things when they go wrong.
4 I am better able to do things that I want to do.
5 My Symptoms are not bothering me as much (this question already is part of the MHSIP Adult Survey)

YSS-F Functioning Domain Items:

1 My child is better able to do things he or she wants to do.
2 My child is better at handling daily life. (existing YSS-F Survey item)
3 My child gets along better with family members. (existing YSS-F Survey item)
4 My child gets along better with friends and other people. (existing YSS-F Survey item)
5 My child is doing better in school and/or work. (existing YSS-F Survey item)
6 My child is better able to cope when things go wrong. (existing YSS-F Survey item)

Items to Score in the Social Connectedness Domain:

Adult MHSIP Social Connectedness Domain:

1 I am happy with the friendships I have.
2 I have people with whom I can do enjoyable things.
3 I feel I belong in my community.
4 In a crisis, I would have the support I need from family or friends.

YSS-F Social Connectedness Domain Items:

1 I know people who will listen and understand me when I need to talk
2 I have people that I am comfortable talking with about my child's problems.
3 In a crisis, I would have the support I need from family or friends.
4 I have people with whom I can do enjoyable things

Table 10. Profile of Agencies Receiving Block Grant Funds Directly from the State MHA

This table is to be used to provide an inventory of providers/agencies who directly receive Block Grant allocations. Only report those programs that receive MHBG funds to provide services. Do not report planning council member reimbursements or other administrative reimbursements related to running the MHBG Program. Use one row for each program

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 10				
Report Year:	2008			
State Identifier:	NE			
Agency Name	**Address**	**Name of Director**	**Phone #**	**Amount of Block Grant Allocation to Agency**
Region 1 Behavioral Health Authority	4110 Avenue D Scottsbluff, NE 69361	Sharyn Wohlers Region 1 Regional Administrator	(308) 635-3171	$186,251
Region 2 Behavioral Health Authority	110 North Bailey Street P.O. Box 1208 North Platte, NE 69103	Kathy Seacrest Region 2 Regional Administrator	(308) 534-0440	$187,795
Region 3 Behavioral Health Authority	4009 6th Avenue, Suite 65 P.O. Box 2555 Kearney, NE 68848	Beth Baxter, M.S. Region 3 Regional Administrator	(308) 237-5113	$268,202
Region 4 Behavioral Health Authority	206 Monroe Avenue Norfolk, NE 68701	Ingrid Gansebom Region 4 Regional Administrator	(402) 370-3100 x 120	$272,545
Region 5 Behavioral Health Authority	1645 "N" Street Suite A Lincoln, NE 68508	CJ Johnson Region 5 Regional Administrator	(402) 441-4343	$438,759
Region 6 Behavioral Health Authority	3801 Harney Street Omaha, NE 68131-3811	Patty Jurjevich Region 6 Regional Administrator	(402) 444-6573	$574,971
		Total FY2008 Allocations		$1,928,523

*** If you need more lines for additional agencies, please add rows or make copies of this table.**

NOTE: The amount of allocation to the six Regions for State Fiscal Year 2008 was $1,928,523. For State Fiscal Year 2009, this allocation was reduced to a total of $1,870,205 which was a cut of $58,318.

Child/Family Consumer Surveys

1. Was the MHSIP Children/Family Survey (YSS-F) Used? ☑ Yes
If No, what survey did you use?

If no, please attach instrument used.

1.c. Did you use any translations of the Child MHSIP into another language? ☑ 1. Spanish
2. Other Language:

Child Survey Approach:

2. Populations covered in survey? (Note all surveys should cover all regions of state)
○ 1. All Consumers in State
◉ 2. Sample of MH Consumers

2.a. If a sample was used, what sample methodology was used?
◉ 1. Random Sample ○ 2. Stratified/Random Stratified Sample
○ 3.Convenience Sample

4. Other Sample:

2.b Do you survey only people currently in services, or do you also Survey Persons no longer in service?
☑ 1. Persons Currently Receiving Services
☐ 2. Persons No Longer Receiving Services

2a. If yes to 2, please describe how your survey persons no longer receiving services.

3. Please Describe the populations included in your sample: (e.g., all children, only children with SED, etc.)
☑ 1. All Child consumers in state
☐ 2. Children with Serious Emotional Disturbances
☐ 3. Children who were Medicaid Eligible or in Medicaid Managed Care

3.4 Other: describe: (for example, if you survey anyone served in the last 3 months, describe that here):

4. Methodology of collecting data? (Check all that apply)

	Self-Administered	Interview
Phone	☐ Yes	☑ Yes
Mail	☑ Yes	
Face-to-face	☐ Yes	☐ Yes
Web-based	☐ Yes	☐ Yes

4.b. Who administered the Survey? (Check all that apply)
☑ 1. MH Consumers
☑ 2. Family Members
☑ 3. Professional Interviewers
☐ 4. MH Clinicians
☐ 5. Non Direct Treatment Staff
6. Other: describe:

5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?
☑ 1. Responses are Anonymous
☑ 2. Responses are Confidential
☐ 3. Responses are Matched to Client databases

6. Sample Size and Response Rate

6a. How many Surveys were Attempted (sent out or calls initiated)?	784
6.b How many survey Contacts were made? (surveys to valid phone numbers or addresses)	306
6.c How many surveys were completed? (survey forms returned or calls completed)	128
6.d. What was your response rate? (number of Completed surveys divided by number of Contacts)	42%

6.e. If you receive "blank" surveys back from consumers (surveys with no responses on them), did you count these survey's as "completed" for the calculation of response rates?
○ Yes ◉ No

7. Who Conducted the Survey

7.a. SMHA Conducted or contracted for the Survey (survey done at state level)
◉ Yes ○ No

7.b. Local Mental Health Providers/County mental health providers conducted or contracted for the survey (survey was done at the local or regional level)
○ Yes ◉ No

7.c. Other: Describe:

Table 11a: Consumer Evaluation of Care by Consumer Characteristics: (Optional Table by Race/Ethnicity.)

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 11a	
Report Year:	2008
State Identifier:	NE

Adult Consumer Survey Results:

*State used the 2 question version for Hispanic Origin: ○ Yes ○ No

Please check the appropriate box on the left. The "Totals" formula will automatically adjust to account for which method your state used to ask about Hispanic Origin/Status

Indicators	Total		American Indian or Alaska Native		Asian		Black or African American		Native Hawaiian or Other Pacific Islander		White		More than One Race Reported		Other/ Not Available		Hispanic Origin*	
Adult Consumer Survey Results:	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses
1. Reporting Positively About Access.	743	974	24	29	7	9	32	42	6	6	636	831	0	0	38	57	41	52
2. Reporting Positively About Quality and Appropriateness.	793	988	25	29	7	9	37	44	4	4	683	826	0	0	37	56	35	49
3. Reporting Positively About Outcomes	699	955	23	29	6	9	29	43	4	5	589	813	0	0	37	56	39	50
4. Reporting Positively about Participation in Treatment Planning	638	873	22	29	6	8	32	41	2	3	544	742	0	0	32	50	34	47
5. Reporting Positively about General Satisfaction	787	1,018	26	30	8	9	34	44	5	6	653	862	0	0	41	59	41	53
6. Social Connectedness	720	944	22	28	7	9	33	43	5	5	617	808	0	0	36	53	39	48
7. Functioning	809	1,006	25	30	5	9	34	43	5	6	702	861	0	0	38	57	41	51

Child/Adolescent Family Survey Results:

*State used the 2 question version for Hispanic Origin: ○ Yes ○ No

Please check the appropriate box on the left. The "Totals" formula will automatically adjust to account for which method your state used to ask about Hispanic Origin/Status

Indicators	Total		American Indian or Alaska Native		Asian		Black or African American		Native Hawaiian or Other Pacific Islander		White		More than One Race Reported		Other/ Not Available		Hispanic Origin*	
Child/Adolescent Family Survey Results:	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses
Reporting Positively About Access.	100	128	3	4	1	1	13	18	0	0	69	89	0	0	14	16	9	10
Reporting Positively About General Satisfaction	86	127	3	4	1	1	9	18	0	0	59	88	0	0	14	16	8	10
Reporting Positively About Outcomes.	79	125	3	4	1	1	8	18	0	0	49	86	0	0	12	16	7	10
Reporting Positively Participation in Treatment Planning for their Children	85	127	3	4	1	1	11	18	0	0	58	88	0	0	14	16	8	10
Reporting Positively About Cultural Sensitivity of Staff.	105	128	4	4	1	1	15	18	0	0	69	89	0	0	16	16	9	10
6. Social Connectedness	103	127	4	4	1	1	15	18	0	0	69	88	0	0	14	16	8	10
7. Functioning	76	125	3	4	1	1	9	18	0	0	51	86	0	0	12	16	7	10

Comments on Data:

Please enter the number of persons responding positively to the questions and the number of total responses within each group. Percent positive will be calculated from these data.

Table 16: Profile of Adults with Serious Mental Illnesses and Children with Serious Emotional Disturbances Receiving Specific Services:

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 16.									
Report Year:	2008								
State Identifier:	NE								
	Adults with Serious Mental Illness (SMI)				Children with Serious Emotional Disturbance (SED)				
	n Receiving Supported Housing	n Receiving Supported Employment	n Receiving Assertive Community Treatment	Total unduplicated N - Adults with SMI served	n Receiving Therapeutic Foster Care	n Receiving Multi-Systemic Therapy	n Receiving Family Functional Therapy	Total unduplicated N - Children with SED	
Age									
0-12									
13-17									
18-20	11	0							
21-64	704	452	222						
65-74	2	1	7						
75+		0							
Not Available		0							
TOTAL	717	453	229	0	0	0	0	0	
Gender									
Female	428	230	112						
Male	289	223	117						
Not Available	0								
Race/Ethnicity									
American Indian/Alaska Native	13	11	0						
Asian	5	2	1						
Black/African American	69	58	42						
Hawaiian/Pacific Islander	1	1	0						
White	610	365	173						
Hispanic*		12	5						
More than one race	14	2	1						
Not Available	5	2	7						
Total by Hispanic/Latino Origin differ		453	229						
Hispanic/Latino Origin									
Hispanic/Latino Origin	28								
Non Hispanic/Latino	673								
Not Available	16								

Do You monitor fidelity for this service?	Yes / No ○ ◉	Yes / No ○ ◉	Yes / No ◉ ○		Yes / No ○ ○	Yes / No ○ ○	Yes / No ○ ○	
IF YES,								
What fidelity measure do you use?								
Who measures fidelity?								
How often is fidelity measured?								
	Yes / No	Yes / No	Yes / No		Yes / No	Yes / No	Yes / No	
Is the SAMHSA EBP Toolkit used to guide EBP implementation?	○ ◉	◉ ○	◉ ○		○ ○	○ ○	○ ○	
Have staff been specifically trained to implement the EBP?	◉ ○	◉ ○	◉ ○		○ ○	○ ○	○ ○	

* Hispanic is part of the total served. ◉ Yes ○ No

Comments on Data:	

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethnic Origin are not available

SUMMARY – NE Division of Behavioral Health Application for
U.S. Department of Justice – Bureau of Justice Assistance (BJA) Grant
Justice and Mental Health Collaboration Program (CDFA #16.745)
CATEGORY II: PLANNING AND IMPLEMENTATION

- Submitted on May 6, 2008 … Award with Project Period: 11/01/2008 to 10/31/2011
- Grant maximum: $250,000 ($100,000 year one; $100,000 year two; $50,000 year three)
- NE Theme: collaborative partnerships to address interagency coordination & communication in order to implement system improvements for persons with MI in the Criminal Justice System.
- Target Population: Young adults 18 to 24 years of age.

Goal 1: Provide statewide Crisis Intervention Team (CIT) training for Law Enforcement officers and make clear linkages with local crisis response teams.

Objectives:
- 1.1 Build on CIT training curriculum and adapt for rural areas and various professions (parole, probation, jail personnel, etc.)
- 1.2 Pilot comprehensive CIT train the trainers training. Trainers will train 20 law enforcement officers in one community
- 1.3 Study impact of pilot project
- 1.4 Implement statewide CIT training for law enforcement
- 1.5 Adapt CIT training curriculum for probation and parole
- 1.6 Pilot CIT train the trainers training for probation and parole and expand statewide

Goal 2: Expand or improve access to crisis stabilization services with improved coordination with law enforcement officers.

Objectives:
- 2.1 Refine model for crisis intervention for transition aged youth through consultation with national expert.
- 2.2 Pilot model for crisis intervention coordination in one community based on local plan for 100 – 200 individuals
- 2.3 Study impact of crisis intervention pilot
- 2.4 Implement crisis intervention model statewide
- 2.5 Implement strategies for sustaining crisis programs

Goal 3: Implement standardized mental health and substance abuse screening instruments in the jails that prompt referrals for services.

Objectives:
- 3.1 Refine plan for standardized screening and assessment process
- 3.2 Incorporate processes into Nebraska jail standards
- 3.3 Develop and provide training and technical assistance for jail personnel
- 3.4 Evaluate impact of change in standards

Goal 4: Increase resources to community mental health to provide diversion services through the use of Forensic Intensive Case Management.

Objectives:
- 4.1 Adopt lessons learned from Nebraska's two urban jail diversion programs to develop a rural model
- 4.2 Pilot rural jail diversion program for transition aged youth in one area of the state in coordination with crisis response teams
- 4.3 Examine service definitions for community support/case management and examine financing approaches for sustainability
- 4.4 Study impact of jail diversion pilot
- 4.5 Implement coordinated jail diversion programs in other areas
- 4.6 Implement strategies for sustaining jail diversion programs through 2009 – 2010 contracts

Goal 5: Enhance affordable supportive housing for justice involved youth transitioning to adulthood.

Objectives:
- 5.1 Collaborate with Nebraska's Action Plan For Increasing Access to Mainstream Services for Persons Experiencing Chronic Homelessness to identify individuals in Department of Correctional Facilities with mental illness ready for release
- 5.2 Develop protocols for developing housing plan and linking individuals with supported housing and supported employment including assessing for Medicaid eligibility
- 5.3 Pilot protocols in Omaha area for 250 transitioning young adults
- 5.4 Provide Rent-Wise Education for 150 consumers in Omaha area

U.S. Department of Justice / Office of Justice Programs / Bureau of Justice Assistance
Justice and Mental Health Collaboration Program (CDFA #16.745)

Awarded to: Nebraska Department of Health and Human Services / Division of Behavioral Health

TITLE OF THE PROGRAM:

Nebraska Justice-Mental Health System Collaboration Planning Project

CATEGORY I: PLANNING
Grant maximum: $50,000.
Project period: 12 months.

PROGRAM PERIOD and BUDGET PERIOD:

From 11/01/2007 To 10/31/2008.

GOAL:

The Overarching Goal for the Office of Justice Programs grant is to improve the cross-disciplinary system of care for persons with mental illness who encounter the criminal justice system in Nebraska by strengthening early intervention efforts to mitigate recidivism and prevent persons, especially juveniles, from cycling through institutionalized settings throughout their lives.

CONTRACTOR:

The grant funds have been contracted to the University of Nebraska Public Policy Center (UNPPC) to facilitate the Strategic Planning Process from initiation to conclusion. Dr. Mark DeKraai, UNPPC Project Director, leads this work. He is a seasoned planning and evaluation expert with a long history of successful collaboration with policy makers and service providers in Nebraska.

The work to be completed includes:

1. Conduct resource/needs assessment and produce report
2. Conduct literature review of best practices to address priority gaps
3. Develop first draft of strategic plan and hold stakeholder meeting
4. Develop final strategic plan

November 3, 2008

Letter to State Advisory Committee on Mental Health Services

Re: RentWise training approved under the Olmstead Act and the Nebraska Federal Community Mental Health Services Block Grant

As discussed in a prior committee meeting, money was allocated to pay for training of RentWise trainers to serve consumers of mental health services across Nebraska. There was an all-day train-the-trainer event at the County Extension Office on Thursday, June 12, 2008. Consumers from Nebraska attended, including Joel McCleary, Dan Powers and Phyllis McCaul from DHHS. David Tafoya and I attended the training and were approved as RentWise trainers. This event was to be paid for from the grant funds.

RentWise is a training consisting of six modules designed to educate renters in all aspects of the rental process from the first application to rent, budgeting, how to properly maintain a rental unit, understanding the lease, etc. The program originated in Minnesota and has been implemented in Nebraska under an agreement with the University of Nebraska and the University of Minnesota.

There are trainings being conducted in Lincoln that include both day and evening classes. This is being done through the Lincoln Housing Authority in collaboration with local landlords, educators and others. John Turner from Region 5 has done an outstanding job of promoting RentWise and working to reduce homelessness in our area.

In my personal opinion, RentWise is a truly outstanding program that can help new renters as well as people who may have had problems with renting in the past. Some landlords in Lincoln are even offering a deduction from the rent deposit to RentWise participants who have completed the entire course and have a completion certificate. My hope, along with the hope of many others, is that this program can grow and develop across Nebraska to assist renters of all ages and experiences.

With all respect for the many hours of hard work and effort that makes RentWise possible in Nebraska, I need to make the committee aware of one problem area.

Prior to the training in June it was our understanding that one trainer from each Region teaching RentWise to other consumers in their area would be paid $100 for each consumer trained if they successfully completed all six modules. The payment was limited to teaching 9 consumers in each region.

A RentWise training was conducted for five consumers of mental health services in August 2008 at Midtown Center. There were four sessions of 2 ½ hours each. David Tafoya was the lead instructor and he was assisted by four other teachers including me. All of the consumers passed the six modules and were given certificates of completion.

As a result David Tafoya had earned $500 for training these individuals. There was considerable time spent preparing for the training in addition to the actual time spent at the training.

Unfortunately, Joel McCleary resigned his position as Consumer Affairs Director for Nebraska. During the transition period no action was taken to pay David for his time. Dan Powers was subsequently appointed interim director of Consumer Affairs pending the search and hiring of the new director.

In recent meetings of the Housing Coalition both Dan Powers and Jim Harvey attended and discussed possibilities for future RentWise training and implementation of the program throughout the state. It was discussed that David Tafoya had not been paid. We were informed that because David did not have a contract with the state that he would not be paid for his work. I stated that it was not acceptable that David would not be paid for this work.

I understand that the transition caused by Joel's resignation created a difficult situation and additional work for the Department. What I do not understand is why David Tafoya will not be paid for his work. I would like to know what the Department plans to do to correct this error. David, as a consumer trainer, did his job in good faith and believing that he was to be paid. Are we not responsible to see that "no further harm" is done here?

Thank you for your attention to this problem.

Pat Talbott

Pat Talbott, Committee member and Vice-chair